To all ers:

The first to be used for purposes of sending information back to your supervisor, after you approve or reject a Plan of Correction (POC). All of the LTC supervisors are using this form for consist on the solution of the lided in the white boxes as applicable. This will assist the supervisors in religion of the survey as required. If you have additional information, include comments or in an email to your supervisor.

#### POC REVIEW/PAPER REVISIT FORM

Facility Hame;	ing and Rehab	Provider ID #: 49-5362				
Is this on No	Jate <u>within 45 days?</u> NO	Date of Admin's Signature: 10/20/17				
Su <b>rvey:</b> 9 <b>/2</b> 9/17	· · · · · · · · · · · · · · · · · · ·	Was this suggest to the same of the same o				
3urvey. <i>3123</i> 7 € 45 days: 11/1 €	Licen <b>sure survey</b> med?	Was this survey a 10 percenter? If so, enter entrance time: NO				
AOC: 111	No					
List below:	s - OR - Insert date on t	his line if AOC date is the <u>same</u> for all tags:				
C1. ALL		02.				
( ·;,		04.				
C .		06.				
0''.	-	08.				
<u>0</u> .		10.				
11 <u>.</u> 13.		12. 14.				
⊣o. Fote of		Date of Facility Notification:				
T Topic	able): 10/23/17	Date Rejection letter/fax (if applicable):				
Late the	Lion: 10/23/17	Date of final Approval after rejection:				
	77. F513 does not h	ong. All but F513 has an AOC of 11/14/17. The nave an AOC date at all. It just says "5. Date of				
	77. F513 does not h	nave an AOC date at all. It just says "5. Date of				
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	77. F513 does not h	nave an AOC date at all. It just says "5. Date of				
10/24/17 TC to	77. F513 does not h	nave an AOC date at all. It just says "5. Date of				

increments (e.g. 0.25, 0.5, etc.):

1.00

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	13 LOK MEDIOVICE	G WILDIONID OF TANOED				180 140. 0930-039
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	4,	TIPLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO
		495362	B. WING	ì		C
<del> </del>		433302			315.0005	09/29/2017
NAME OF F	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE	ZIP CODE	
ASHLAN	D NURSING AND REI	HABILITATION		906 THOMPSON STREET		
7.0112.114				ASHLAND, VA 23005	<u> </u>	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ITEMENT OF OEFICIENCIES  Y MUST BE PRECEOED BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		CTION SHOULO D THE APPROP NCY)	DBE COMPLETION PRIATE OATE
E 000		re	E.	000	RE	CEIVED T 20 2017 H/OLC
F 000	INITIAL COMMEN	13		000	nr	TA
	An unannounced N	Medicare/Medicaid standard	•		υL	1 2 0 2017
		ted 9/26/17 through 9/29/17.	× .		N A P	A B M area
		vestigated during the survey.			w Lj	MOLC
		uired for compliance with 42		F157		
	CFR Part 483 Fede	eral Long Term Care		1.Residen	t#2 suffere	d
		Life Safety code survey/report		no advers	e effects a	nd
	will follow.				quire trans	
	The census in this	190 certified bed facility was				
	169 at the time of the	he survey. The survey sample			r level of ca	
		rent resident reviews			n order wa:	
	(Residents #1 throu	ugh #23 and #31 through #32)		obtained t	to discontin	nue
	through #30).	d reviews (Residents #24		Resident#	2's order fo	or
F 157	483.10(g)(14) NOT	IFY OF CHANGES	F	157 Urinalysis.	The Physic	ian
<b>s</b> S=D	(INJURY/DECLINE/ROOM, ETC)				nsible party	
	(g)(14) Notification	of Changes.			ied. Reside	=
	(i) A facility must im	mediately inform the resident;			ed no advei	rse
		ident's physician; and notify,		effects and	l did not	
	consistent with his	or her authority, the resident		require tra	nsfer to	
	representative(s) w	hen there is-		higher leve	el of care. A	
	(A) An accident inv	olving the resident which		physician c		
	results in injury and	I has the potential for requiring		Resident#1		n
	physician interventi			culture to i	•	1
	(D) A significant of	ange in the resident's physical,		· ·	- <del>-</del>	
	mental or osvobosi	ocial status (that is, a		discontinue		
		Ith, mental, or psychosocial		obtained b	•	
	status in either life-	threatening conditions or		Physician.	The Physici	an
	clinical complication	ns);		and the res	ponsible	
	(C) A mand to obtain	treatment significantly (that is,		party receiv	•	
	a need to disconting	ue an existing form of		notification		
		lverse consequences, or to		Hotification	•	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0.0938-0391
	OF DEFICIENCIES F CORRECTION	(X1)_ PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495362	B. WING			00	C 9/29/2017
	PROVIDER OR SUPPLIER D NURSING AND REI	HABILITATION		90	REET ADDRESS. CITY, STATE, ZIP CODE 6 THOMPSON STREET	·	720720 [ ]
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	(D) A decision to tra resident from the far §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informatics available and prophysician.  (iii) The facility must resident and the resid	orm of treatment); or ensfer or discharge the acility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the  It also promptly notify the sident representative, if any, or or roommate assignment 3.10(e)(6); or ident rights under Federal or cions as specified in paragraph on. It record and periodically (mailing and email) and the resident representative(s). It is not met as evidenced or o	F 1	157	2. A quality review of current residents with physician orders for laboratory testing had been performed. Physician notification related to laboratory results is in present in the chart.  3. Licensed Nurses re educated by DCS/Designee regard following Physician orders on obtaining laboratory specimen and the process in following up with	h s	
	change in status an residents in the sur- #15.	notify the physician of a d treatment for two of 34 vey sample; Residents #2 and failed to notify the physician					

when a urinalysis laboratory specimen was not obtained as ordered on 5/26/17 for Resident #2.

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	F OEFICIENCIES CORPECTION	(X1)**PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER \$\frac{\psi}{2}\$	L	IPLE CONSTRUCTION NG	(X3) OA	TE SURVEY MPLETEO  C 9/29/2017
1	E OF PROVIOER OR SUPPLIER  ILAND NURSING AND REHABILITATION			STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND, VA 23005		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES IO  (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFI  REGULATORY OR LSC IOENTIFYING INFORMATION) TAG		PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO BE	(X5) COMPLETION OATE	



#### 157 Continued From page 2

2. The facility staff failed to notify the physician when a sputum culture and sensitivity was not obtained as ordered on 9/2/17 for Resident #15.

#### The findings include:

1. The facility staff failed to notify the physician when a urinalysis laboratory specimen was not obtained as ordered on 5/26/17 for Resident #2.

Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV (human immunodeficiency virus), dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded Resident #2 as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the resident's comprehensive care plan developed on 5/6/17 did not address obtaining urine specimens.

Review of Resident #2's physician orders dated on 5/26/17 documented, "Clean Catch U + A (urine and analysis) on 5/30/17."

Review of the clinical record did not evidence documentation of the urine specimen results.

A request was made on 9/27/17 at 1:45 p.m. of ASM (administrative staff member) #1, the administrator/executive director, for a copy of the urine specimen results.

F 157

laboratory results including Physician and RP notification.
DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of physician laboratory orders, contacting the Physician and RP notification daily x4, weeklyx4 and then monthly, PRN and as indicated.

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CENTERS FOR	MEDICARE	& MEDICAID SERVICES				OMB N	D. 0938-0391
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		495362	B. WING				C
NAME OF PROVIDER ASHLAND NURS	SING AND RE	HABILITATION	10	90 <b>6 T</b>	ET ADORESS, CITY, STATE, ZIP COO HOMPSON STREET LAND, VA 23005 PROVIOER'S PLAN OF CORR	OE	9/29/2017
PREFIX (E/	CH OEFICIENC	Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO BE	(X5) COMPLETION DATE
a.m. w service (labora discond	griview was contith ASM #2, as. ASM #2 set ory specime tinued." (The tinue the uring asked when ere not able in "It probably an wants. I was erview was contith LPN (lice asked when ere not able in was notification asked when ere not able in was notification region. Left in the facility of the information region. Failure on appropriation. Failure on appropriation to the per are caused avoid being standards of	and and a state of the director of nursing/clinical stated, "I don't have the laben) which is why the order was a staff obtained an order to be specimen order on 9/27/17.) staff notified the physician if to follow an order, ASM #2 depends on what the would say a day."  Inducted on 9/28/17 at 12:25 ansed practical nurse) #3. staff notified a physician if to follow an order, LPN #3 ay." When asked when the lied if staff could not obtain a lin #3 stated, "It was an order. I ctor and notify the next shift."  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.  It is policy titled, "Laboratory, lay" did not evidence arding notifying the physician if to obtain a laboratory.	, F	157	4.DCS/Designer conduct quality monitoring regression notification with document the medical regindicated. Find communicated QAPI committed monthly and a indicated. Qual monitoring solution modified base findings  5. November 1.	garding fication in ecord as dings to be do the ee as ality hedules	

providers. The physician or health care provider

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB !	NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBERS			CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495362	B. WING				C 09/29/2017
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/23/2011
1					THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION 			HLAND, VA 23005		
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F 157	Continued From pa is responsible for d of a patient.	age 4 irecting the medical treatment.	F	157			
	when a sputum cul	failed to notify the physician ture and sensitivity was not d on 9/2/17 for Resident #15.					
	10/3/16 with diagnoral limited to: seizures disease, diabetes, stroke. The most reassessment, with a resident as having BIMS (brief interviet the resident was condecisions. The resident	admitted to the facility on oses that included but were not sees that included but were not solve the scent MDS, a quarterly an ARD of 7/7/17 coded the scored a 13 out of 15 on the way for mental status) indicating ognitively intact to make daily dent was coded as requiring aff for all activities of daily					
	10/13/16 and revise	t #15's care plan initiated on ed on 7/26/17 did not evidence ated to obtaining sputum			·	÷	
	Review of the phys documented, "Obta sensitivity) on Tues	ician's orders dated 9/2/17 ain sputum c+s (cuiture and day (9/5/17)."					
	documentation of t request was made ASM (Administrativ	cal record did not evidence he sputum specimen results. A on 9/27/17 at 1:45 p.m. of ve Staff Member) #1, the utive director, for a copy of the results.					

An interview was conducted on 9/28/17 at 10:58 a.m. with ASM #2, the director of nursing/clinical

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OLIVILI	CO L OLL INITION ALE						VID INC. C	1900-009
	TATEMENT OF DEFICIENCIES (X1): PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBERS: A. BUILDING				(X3) DATE SURVEY COMPLETED			
		495362	B. WING				. C	
							1 09/2	9/2017
	ROVIOER OR SUPPLIER  D NURSING AND RE	HABILITATION	·	906 1	ET ADDRESS, CIT THOMPSON STRI LAND, VA 230			
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F 157	(laboratory specime discontinued." (The discontinue the sput When asked when they were not able stated, "It probably physician wants. I wanterview was cop.m. with LPN (lice When asked when they were not able stated, "Within a daphysician was notif sputum specimen for the specimen of the stated of the stated of the stated of the specimen of the spec	stated, "I don't have the laben) which is why the order was e staff obtained an order to utum specimen on 9/27/17.) staff notified the physician if to follow an order, ASM #2 depends on what the would say a day."  Inducted on 9/28/17 at 12:25 ansed practical nurse) #3. staff notified a physician if to follow an order, LPN #3 ay." When asked when the lied if staff could not obtain a for culture and sensitivity as	F	157				
F 166 SS=D	an order. I would no next shift."  No further informat 483.10(j)(2)-(4) RIG TO RESOLVE GRI  (j)(2) The resident I must make prompt grievances the resi with this paragraph  (j)(3) The facility must of file a grievance or resident.  (j)(4) The facility must facility must make prompt grievance or sident.	nas the right to and the facility efforts by the facility to resolve dent may have, in accordance		166	F166 1. 2.	Resident #3's gron 1/25/17 har resolved. The administrativith Resident coinquire about unresolved grief All grievances as	s been or met buncil to any evances.	
	regarding the residence paragraph. Upon re	ents' rights contained in this equest, the provider must give ance policy to the resident. The				date and hav resolved.	e been	

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		O MEDICALD SERVICES					FURM APPRUVED
		& MEDICAID SERVICES	<u> </u>		<del></del>	•	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) @ROVIDER/SUPPLIER/CLIA, IDENTIFICATION NUMBER:			CONSTRUCT		(X3) DATE SURVEY COMPLETED
		495362	B. WING				C 09/29/2017
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRE	SS, CITY, STATE, ZIP CODE	
4.0011.44	D NURSING AND RE	HARII ITATION		906	THOMPSO	N STREET	
ASHLAN	D MOKSHAG AIAD IVE	(IABIETATION		AS	HLAND, V	A 23005	
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F 166	Continued From pa	age 6	F '	166			
	grievance policy m						
	(i) Notifying resider postings in prominfacility of the right to (meaning spoken) grievances anonymof the grievance of can be filed, that is address (mailing a number; a reasonate completing the revito obtain a written grievance; and the independent entities be filed, that is, the Quality Improvemed Agency and State program or protect (ii) Identifying a Griesponsible for overeceiving and track conclusions; leading by the facility; main information associexample, the identifying and track conclusions; and the identifying and track conclusions; leading by the facility; main information associexample, the identifying and track coordinating with sinecessary in light of the post of the identifying and track coordinating with sinecessary in light of the identifying and track coordinating with sinecessary in light of the identification.	nt individually or through ent locations throughout the ofile grievances orally or in writing; the right to file mously; the contact information ficial with whom a grievance of the mously and business phone able expected time frame for iew of the grievance; the right decision regarding his or her contact information of es with whom grievances may a pertinent State agency, and Organization, State Survey Long-Term Care Ombudsman and advocacy system; itevance Official who is perseeing the grievance process, king grievances through to their any necessary investigations attaining the confidentiality of all atted with grievances, for ity of the resident for those ted anonymously, issuing decisions to the resident; and state and federal agencies as of specific allegations;			3.	Quality monitoring to conducted 3X a we per week for 4 weeks ensure compliance a then 1X a week point and the quarterly thereaft Quality monitorischedule to be modificated.	ed ace ure ed ed ang nd uct of og be ek to and eer en eer. ang
	prevent further pot	taking immediate action to ential violations of any resident ged violation is being				based on findings quality reviews. T	of he

(iv) Consistent with §483.12(c)(1), immediately

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				C		NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1)_PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILD		ONSTRUCT		1	) DATE SURVEY COMPLETED
		495362	B. WING	s				C 09/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRE	SS, CITY, STATE, ZIP CODE	<u> </u>	09/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		1		N STREET A 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION E OATE
F 166	abuse, including injand/or misappropria anyone furnishing sprovider, to the admas required by State (v) Ensuring that all include the date the summary statementhe steps taken to its summary of the per regarding the reside as to whether the gronfirmed, any corritaken by the facility and the date the wroten (vi) Taking appropriaccordance with State Survey Agorganization, or loc confirms, a violation rights within its area (vii) Maintaining evicesult of all grievand 3 years from the iss decision. This REQUIREMENT by:  Based on staff intereview, clinical recordination investigation.	I violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and a law;  written grievance decisions a grievance was received, a stof the resident's grievance, a stinent findings or conclusions and source action taken or to be as a result of the grievance, itten decision was issued;  ate corrective action in ate law if the alleged violation at law enforcement agency, Quality Improvement allaw enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than unnce of the grievance  IT is not met as evidenced review, facility document ard review and in the course of tion, it was determined that		166	. 5.	results of the Quamonitoring to reviewed at the mont quality assurar performance Improvement (QAmeetings for reviewanalysis and furth recommendations. November 14, 2017	be hly nce PI)	
		ion, it was determined that resolve a reported grievance						

for one of 34 residents in the survey sample,

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				FORM	MAPPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2] MUL	TIPL	LE CONSTRUCTION		0. 0938-0391 TE SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:				CO	MPLETED
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NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	B. WING			09	9/29/2017
	•		1		STREET ADDRESS, CITY, STATE, ZIP CODE 106 THOMPSON STREET		
ASHLAN	ID NURSING AND RE	HABILITATION			ASHLAND, VA 23005		
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD	O RE	[X5] COMPLETION
					CROSS-REFERENCED TO THE APPROP DEFICIENCY]	RIATE	OATE
F 166	Continued From pa	age 8	F 1	166			
	The facility staff fai	I-da recelus Posident #3's					
		iled to resolve Resident #3's I to the social worker by the					
	responsible party (I	RP) about a missing laundry					
1	basket full of dirty of	clothes in January of 2017.					
ļ ·							
	The findings includ	le:					
	-					-	
		dmitted to the facility on oses that included but were not					
		nrenia, Alzheimer's Disease,					
	enlarged thyroid, de	epression and glaucoma.					
•		t recent MDS (minimum data					
•		vas a quarterly assessment with ent reference date) of 8/24/17.					
}		oded as being severely					
	impaired in cognitiv	ve function scoring 04 out of 15					•
		Interview for Mental Status)  3 was coded as requiring			·		
		ith transfers, ambulation,					
	locomotion, and ea	ating; minimal assistance with					,
		with dressing, and personal					
	hygiene; and exten member with bathir	nsive assistance with one staff					
	member marsass.						÷
		uary 2017 grievance logs					•
		: #3's son (responsible party) ance on 1/25/17 about					
		sing clothes. The following was					* *
	documented, "1/25.	5/17 Resident (Resident #3) is					
		y basket with her dirty clothes					
		he facility does the resident's still pending with Laundry					
	Director."	· ·					
	= 0	' !- an failed to					
;	further review of the document the outcoment	ne grievance logs failed to ome of Resident #3's					

grievance from 1/25/17.

		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM APPROVED 0MB NO. 0938-0391
	NT OF OEFICIENCIES N OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495362	B. WING_		C 09/29/2017
	F PROVIDER OR SUPPLIER	HABILITATION		STREET ADORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) IC PREFIX TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO OEFICIENCY)	LO RE COMPLETION
F 16	66 Continued From pa	age 9	F 16	56	
		t #3's clinical record failed to bout a missing laundry basket.			
	conducted with OS the social worker. process followed b family member rep member. OSM #7 concern, will take in	p.m., an interview was 'M (Other staff member) #7, OSM #7 was asked about the y staff when a resident or orts a grievance to a staff stated, "Whoever takes the t to social services and then we			

after the grievance form is completed, she will take the concern to administration. OSM #7 stated if the grievance is regarding missing clothing, administration will have staff look for the articles of clothing in laundry or throughout the facility. OSM #7 stated if the facility cannot locate the missing clothing, the facility will reimburse the resident/family and then fill out a Petty Cash Reimbursement form. When asked if the resident or family member is always reimbursed in cash, OSM #7 stated that they will call the resident or family and ask if they would rather be reimbursed in cash or have the item (s) replaced. When asked if she was familiar with the above grievance filed on 1/25/17 from Resident #3's RP, OSM #7 stated she was not. OSM #7 stated another social worker worked at the facility during that time. OSM #7 stated sometime in June of 2017, Resident #3's son had placed copies of receipts in her box and requested that he be reimbursed for missing clothing. OSM #7 stated she had the laundry director look for the clothes that were supposedly missing. OSM #7 stated the facility reimbursed Resident #3's RP when the clothes were unable to be located. When asked if the missing clothes reported in June 2017, were

the same clothes that were missing back in

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OI	FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		NSTRUCTION		(X3) DATE SURVEY COMPLETED
1		495362	B. WING				C
NAME OF F	PROVIOER OR SUPPLIER	<del></del>		STREE	ET AOORESS, CITY, STATE, ZIP	COOE	09/29/2017
ASHLAN	D NURSING AND REI	HABILITATION		906 T	HOMPSON STREET  LAND, VA 23005	0002	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCEO TO TH OEFICIENCY)	N SHOULD E APPROPI	BE COMPLETION
F 166	#7 stated she would grievance back in John to resolve the conclaundry director was previous laundry diabove concern and with the facility.  On 9/27/17 at 3:08 conducted with OS laundry aide who he few years. When at that a resident is mosmous of the laundry dand then her boss that she will then so that she will then so that she will then so that she was never on 9/27/17 at 4:00 conducted with OS housekeeping and the above grievance was not the laundry on 9/27/17 at 5:43 conducted with OS could not find any in the was not sure how to OSM #7 had also preceipts Resident in June of 2017. A	age 10 stated she was not sure. OSM d try to find the soft file for the lanuary to see what was done ern. When asked if the s available, OSM #7 stated the rector would be familiar with he was no longer employed  p.m., an interview was M (other staff member) #11, a ad worked at the facility for a asked how she is made aware lissing an article of clothing, at administration will tell her lirector) about the missing item will tell her. OSM #11 stated earch for the item (s). OSM I Resident #3's missing of dirty clothes. OSM #11 ver made aware of it.  p.m., an interview was M #13, the director of laundry. He could not recall lie. OSM #13 stated that he y director at that time.  p.m., further interview was M #7. OSM #7 stated she information regarding Resident l/25/17. OSM #7 stated she he grievance was resolved. Interview of the lift of th	F	166	OLFICIENC!)		
	following was docu	mented: "Date of Request: ent receipts attached:					

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES					FORM APPROVED 1B NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION		X3) DATE SURVEY COMPLETED
		495362	B. WING_				C 09/29/2017
NAME OF	PROVIOER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP COE	Έ	00/20/2011
ASHLAN	D NURSING AND RE	HABILITATION			HOMPSON STREET AND, VA 23005		:
(X4110 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD E	BE COMPLETION
F 166	resident is missing pants, stretch pant reimbursement red also presented a composition of the pants of the pa	n, (Name of son) stated that these items. Missing clothes ats, socks. Amount quested: \$135.95." OSM #7 opy of an email from Resident to the had received the clothes. The following was ame of RP) POA (power of \$135.00 cash in regards to the theorem is removed in the process followed if a member reports a concern, arievance or concern can be aff member and that staff en fill out a grievance concern ted the form is given to then administration will try to the concern is regarding a SM #1 stated she will try to the could recall Resident #3's party) concern for a missing of dirty clothes back in January stated she was not sure. ASM and the stated she was not sure. ASM and ld look to see what was done to	·	6			
		1/25/17 was resolved. ASM #1					

was made aware of the above concerns,

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CENTERS	FUR WEDICARE	- & MEDICAID SERVICES	<del></del>		OMB NO	. 0938-0391
STATEMENT OF C	FOEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOII	IPLE CONSTRUCTION NG	(X3) OAT	TE SURVEY MPLETEO
	<u></u>	495362	8. WING_		09	C /29/2017
NAME OF PRO	NAME OF PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP (		
ASHLAND	NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO BE EAPPROPRIATE	IX5) COMPLETION DATE

F 166 Continued From page 12

F 166

Facility policy titled, "Complaint/Grievance" documents in part, the following: "Purpose: To support each resident's right to voice grievances; resulting in a follow-up and resolution while keeping the resident apprised of it progress toward resolution. Process: An employee receiving a complaint/grievance from a resident, family member and/or visitor shall initiate a Complaint/Grievance Form or electronic equivalent. - Complaint/Grievance forms will be available 24 hours per day 7 days a week in an unsecured common area. - Accommodations will be made to ensure residents have the opportunity regardless of their physical abilities or limitations. Original grievance forms are then submitted to the Grievance Officer/designee for further action. The Grievance Officer/designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. The findings of the grievance shall be recorded on the Complaint /Grievance form or electronic equivalent. Once the follow up is complete, the results should be forwarded to the Executive Director for review and filing. The executive director/designee will log complaints/grievances in Monthly Grievance Log or electronic equivalent. The individual voicing the grievance shall receive follow up communication with the resolution, a copy of the orievance resolution will be provided to the resident upon request."

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>		<del> </del>	· <u>_</u> _· C	)MB N	<u>0. 0938-0</u> 391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBERS	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DA	ATE SURVEY DMPLETED
		495362	B. WING			<del></del>	0	C 9/29/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS	S, CITY, STATE, ZIP CODE		
A CLU A N	ID NURSING AND RE	HARII ITATION		9(	06 THOMPSON	STREET		
ASTLAN	D NONSING AND INC		ļ	Α	ASHLAND, VA	23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG		(EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL FERENCEO TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 167 SS≃C	483.10(g)(10)(i)(11 RESULTS - READ	) RIGHT TO SURVEY ILY ACCESSIBLE	F1	167				
	(g)(10) The resider	nt has the right to-			F 167	•		
	(3)((-)				1.	The Plan of corre		
		sults of the most recent survey	•		1.			
		ucted by Federal or State				from the last Stan		
	respect to the facili	plan of correction in effect with	l			Survey (2016) is po	sted	
•	respect to the racin	ity, and				in the Survey Re	sults	
	(g)(11) The facility	must			•	Binder and Binde		
	(i) Post in a place r	readily accessible to residents,				clearly marked for	easv	
		rs and legal representatives of				identification.	,	
		Its of the most recent survey or			2	~	ماجيي	
	the facility.						ough	
	(ii) House reports wi	th respect to any surveys,				Resident Meeting		•
		complaint investigations made				been notified of Su	•	-
		lity during the 3 preceding				Results Binder locati	on.	
ļ		n of correction in effect with			3.	The Administrator	and	· ·
		ity, available for any individual				or designee re-educ	ated	<u>.</u>
	to review upon req	uest, and					rent	
	(iii) Post notice of t	he availability of such reports in	η.			7		<u>.</u> -
	areas of the facility	that are prominent and					eam	
	accessible to the p	ublic.					sults	- •
	(iv) The facility cha	di not maka available identifyin	~			Binder requirement	to	
		ill not make available identifyin complainants or residents.	A			ensure compliance	with	
		NT is not met as evidenced				requirement to	post	•
	by:					Plans of Correction	•	•
		tion and staff interview, it was				Survey Binder	for	
		cility staff failed to ensure the room the last standard survey				Including Plans		-
	was in the survey r						of	
	·	•				corrections in Su	rvey	•
	correction from the	led to ensure the plan of last standard survey dated he survey results binder.				Results Binder.		

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1): PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. QUILDING			(X3) DATE SURVEY COMPLETED
		495362	B. WING			C 09/29/2017
NAME OF P	ROVIDER DR SUPPLIER		·	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 09/29/2017
ASHLAN	NURSING AND RE	HABILITATION		906	THOMPSON STREET	
ASTILAN		×		ASI	HLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 167	Continued From pa	age 14	F	167	4. The Administrator and	
	<u>.</u>		·		or designee to conduct	
					Quality Monitoring of	
	The findings includ	le:	•		Survey Results Binder	
ļ	On 9/28/17 at 5:30 p.m., observation of the survey results binder was conducted. The binder contained surveys from the past two years. The POC (plan of correction) from the last standard				for including Plans of	
] .					Corrections. Quality	
					Monitoring to be	
	survey conducted the binder.	10/6/16, could not be found in			conducted 3X a week	-
					per week for 4 weeks to	
	On 9/28/17 at 7:40 a.m., the POC from the last standard survey was requested from ASM				ensure compliance and	
		ff member) #2, the DON			then 1X a week per	
		g)/clinical services. ASM #2			month and then	
		C should be in survey results hecked the binder, could not			quarterly thereafter.	. S
		stated she would go try to find			Quality Monitoring	
1	the POC.				Schedule to be modified	•
	On 9/28/17 at 8:00	a.m., ASM #1, (the executive			based on the findings of .	
-	director/administra	itor) stated, "You got me.			the Quality Reviews.	
		asking for a copy of the 2567, I wrong one back in the binder."			The results of the	
	ASM #1 stated she	e was responsible for			Quality Monitoring to	
	maintaining the su	rvey results binder.			· ·	
	On 9/28/17 at 8:00	a.m., ASM #1 and ASM #2				
	were made aware	of the above concerns. No			, , ,	
		was presented prior to exit.	_	004	Assurance Performance	
F 221 SS≈D	483.10(e)(1), 483. FROM PHYSICAL	12(a)(2) RIGHT TO BE FREE RESTRAINTS	г	221	Improvement (QAPI) meetings for review,	
	§483.10(e) Respe	ct and Dignity.			analysis and further	
	The resident has a	a right to be treated with respect			recommendations.	
	and dignity, includi	-			5. November 14, 2017	·

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			C		APPROVED . 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLJA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
		495362	B. WING	3	······································	00	C /29/2017	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET AOORESS, CITY, STATE, ZIP CODE	1 03	12912011	
ASHLAN	D NURSING AND RE	HABILITATION			06 THOMPSON STREET ASHLAND, VA 23005			
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES  Y MUST BE PRECEOEO BY FULL  SC IDENTIFYING INFORMATION)	IO PREFI TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	DBF	IX5I COMPLETION DATE	
F 221	Continued From pa	age 15	F2	221				
	physical or chemical purposes of discipl	olal restraints imposed for ine or convenience, and not e resident's medical symptoms,		£2 1			-	
	The resident has the neglect, misappropriate and exploitation as includes but is not a corporal punishment.	ne right to be free from abuse, priation of resident property, defined in this subpart. This limited to freedom from nt, involuntary seclusion and emical restraint not required to						
	(a) The facility mus	t- -						
	or chemical restrain discipline or conver- required to treat the symptoms. When indicated, the facilit alternative for the le document ongoing restraints.	resident is free from physical nts imposed for purposes of nience and that are not e resident's medical the use of restraints is by must use the least restrictive east amount of time and re-evaluation of the need for	·					

2/10/17.

#1.

Based on observation, staff interview, facility

course of a complaint investigation, it was

document review, clinical record review and in the

determined that the facility staff failed to ensure a resident was free from a physical restraint for one of 34 residents in the survey sample, Resident

Resident #1 was inappropriately restrained to a wheelchair without an evaluation or monitoring on Past noncompliance: no plan of .

correction required.

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CONSTRUCTION	MB NO. 0938-0391 (X3) OATE SURVEY COMPLETEO C 09/29/2017
	C 09/29/2017
EET AOORESS, CITY, STATE, ZIP COOE	1 -0,120,201,
THOMPSON STREET HLAND, VA 23005	
PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	D BE COMPLETION
	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPRIES.)

F 221 Continued From page 16

F 221

The findings include:

Resident #1 was admitted to the facility on 3/28/16. Resident #1's diagnoses included but were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/4/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #1 as being totally dependent of one staff with transfers, locomotion, dressing, eating and personal hygiene.

Review of Resident #1's clinical record failed to reveal any assessments regarding physical restraints. Resident #1's comprehensive care plan initialed on 8/29/16 documented the resident presented with behaviors such as playing with feces, attempting to stand/transfer without assistance and combative behaviors. The care plan failed to document information regarding a physical restraint.

A nurse's note dated 2/10/17 documented, "Rn (registered nurse) observed resident secured to wheelchair with blanket. Blanket immediately removed. Resident alert and confused, lungs clear, abdomen soft and nontender. Resident with old scabs to the L (left) forearm and left hand...No observable s/sx (signs or symptoms) bruising or distress. MD (medical doctor)/RP (responsible party) made aware of incident. Law enforcement notified. Resident will continue to be monitored."

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	FORM	APPROVED
	OF OFFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		). 0938-0391 TE SURVEY
ANO PLAN U	OF CORRECTION	IOENTIFICATION NUMBER:	A. BUILOI	ING_			MPLETEO
		405363					С
11115051		495362	B. WING			09	/29/2017
NAME UF	PROVIOER OR SUPPLIER		-		REET AOORESS, CITY, STATE, ZIP COOE	· <del></del> -	<u></u> -
ASHLAN	ID NURSING AND REI	HABILITATION			6 THOMPSON STREET		ļ
ļ				A	SHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI) TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP	DBE	IX5  COMPLETION DATE
					OEFICIENCY)	1 511	!
- 504							
F 221	Continued From pa	<del>-</del>	F 2	!21			•
		rted incident) submitted to the					
]		nt of Health Office of Licensure					
		n 2/10/17 documented, "Report					
		ncident date: 2/10/2017. X' beside) Allegation of					
,		x beside) Allegation of escribe incident, including					
		n taken: The Director of Clinical					
}	•	d to the secured unit this					
ļ		(certified nursing assistant)					• •
		the said resident (Resident #1)					
	sitting in his wheeld	chair with the ties of a blanket					
		ck of the wheelchair. The					
		Services immediately released					
		sed the resident and found him					
}		istress, no bruises or skin					
-		ne Director of Clinical Services					
		inded the CNAs and the Nurse of Resident #1). The					
		essed by the Medical Director					-
ŀ		ound to be in no acute distress	-				;
		bruising or skin issues noted.	•				
		s assessed (name of Resident					
		seline and he appears to have				•	-
İ	suffered no distress	s from this incident. We will					•
		r the resident for adverse					
	affects (sic) as we	complete a full investigation. A				-	
		completed within 5 working					
	days and sent to yo	our office"					
	The final report out	ittad to the Office of					<del>-</del> -
	Licensure and Cert	omitted to the Office of tification on 2/16/17					
		is a follow up to an initial					
		ncident filing submitted to your					
		10, 2017 involving resident					
	(name of Resident	#1). (Name of Resident #1) is					l
	à 66 y/o (year old) r	resident with the following					l
•		ension (high blood pressure),					

Repeated Falls, Dementia with behavioral disturbances. He has been assessed to be

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CENTERS FOR MEDIC	ARE & MEDICAID SERVICES	· , <u>-</u> ,		MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495362	8. WING		C 09/29/2017		
ASHLAND NURSING ANI		906	REET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CDRRECTION SHOULD CROSS-REFERENCED TO THE APPROPRICE OF THE APPROPRIEMENCY)	D.B.E. COMPLETION		
F 221 Continued Fro	m page 18	F 221				

cognitively impaired with a BIMS (brief interview for mental status) score of 0. On February 10, 2017, the Director of Clinical Services was called to the secured unit by a CNA and she observed (name of Resident #1) with the ties of a blanket fastened to the back of his wheelchair. The Director of Clinical Services immediately released the ties and assessed the resident and found him to be in no acute distress, no bruises or skin changes noted. The Director of Clinical Services immediately suspended the CNAs and the Nurse attending to (name of Resident #1). The resident was assessed by the Medical Director of the facility and found to be in no acute distress and no observable bruising or skin issues noted. Social Services has assessed (name of Resident #1) and he appears to have suffered no distress from this incident. CNA (name) was suspended. CNA, (name) was suspended. CNA, (name) was suspended and LPN (licensed practical nurse) (name) was suspended pending investigation. The Town of Ashland Police Department was contacted and Patrol Officer (name) responded with report number (number). Interviews with Staff were conducted to reveal that (name) is the CNA that cared for (name of Resident #1) and fastened the ties of the blanket to (name of Resident #1's) wheelchair. Based on the evidence above, the allegation was substantiated and (name of CNA) has been terminated. (Name of CNA) has also been reported to the board of Nursing. The center will continue to monitor (name of Resident #1) related to this incident and intervene accordingly. If you have any questions or concerns, please don't hesitate to contact me."

Multiple observations of Resident #1 were conducted during the survey. A one on one sitter was with the resident during each observation.

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	RS FOR MEDICARE	& MEDICAID SERVICES	,		FORM APPROVED OMB NO. 0938-0391
	STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495362	B. WING		C 09/29/2017
NAME OF	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COO	E
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCEO TO THE AP OEFICIENCY)	OULO BE COMPLETION
F 221	F 221 Continued From page 19		F 2	21	
	No concerns regar identified.	ding a physical restraint were			
	conducted with CN #9, an employee w 2/10/17. CNA #9 s Resident #1 was n CNA #9 stated she director of clinical s stayed with Reside untied the restraint director of clinical s describe how Resi stated the resident stated the front of resident's lap and rolled up and tied a back of the wheeld Attempts to contact Resident #1's unit	5 a.m. an interview was A (certified nursing assistant) working on Resident #1's unit or stated on 2/10/17 she noticed of moving and was tied up. If got another CNA who got the services while she (CNA #9) and #1. CNA #9 stated she a little while waiting for the services. When asked to dent #1 was tied up, CNA #9 was in a wheelchair. CNA #9 a sheet was covering the the back of the sheet was around the resident and the shair.  If the other staff working on on 2/10/17 were conducted The staff were not available			

On 9/27/17 at 5:37 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of nursing/clinical services). ASM #2 stated on the morning of 2/10/17 a CNA called her to come to Resident #1's unit. ASM #2 stated when she got to the unit Resident #1 was sitting upright in a wheelchair and she inquired what was going on. ASM #2 stated Resident #1 had a blanket around his waist and the staff motioned for her to look at the back of the wheelchair. ASM #2 stated Resident #1 was tied to the wheelchair. ASM #2 stated she released the resident, completed a full body assessment, a pain assessment and started an

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	MAPPROVE <u>0. 0938-039</u>	D
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		CONSTRUCTION	(X3) D	O. 0936-035 ATE SURVEY OMPLETED	<u>11</u>
		495362	B. WING			,	C	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	_ 1 _ 0	9/29/2017	
ASHLA	ND NURSING AND RE	HABILITATION			THOMPSON STREET HLAND, VA 23005			
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETIO DATE	— N
F 221	administrator to the the Office of Licens notified the residen party. ASM #2 star securing a blanket on the investigation was more than like CNA and reported health professions. completed a full ab On 9/27/17 at appr (the executive direwere made aware). The facility policy ti documented, "Resconsiderate and reunder all circumstate personal dignity are manner. As needed will evaluate the rephysical restraint. restrictive means a identified by the interestrictive means a identified by the	age 20 If #2 stated she called the equit, called the police, notified sure and Certification, and it's physician and responsible ted no one admitted to around Resident #1 but based in she identified the CNA that ely responsible, terminated the the CNA to the department of ASM #2 stated she also cuse in-service with staff.  In eximately 6:00 p.m. ASM #1 ctor/administrator) and ASM #2 of the above concern.  Itled, "Physical Restraints" idents have the right to spectful care at all times and sinces, with recognition of their disafety in the least restrictive ed, the interdisciplinary team sident for the potential need for The restraint must be the least endisciplinary team and/or a ing further intervention due to ternative methods will be estraint application will be estraint application will be estraint application will be entiplan of correction dated ed, "1. A resident was ed and assessed by Nursing dical doctor/responsible party)	F2	21				

and the authorities were immediately notified. Notification was sent to APS (adult protective

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<u> </u>	TO LOTE WILD TO TAKE	THE STORES OF TOTAL				<u></u> OM₿	NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SLIPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MLI A. BLIILO		DNSTRUCTION		B) OATE SURVEY COMPLETEO
		495362	B. WING				C 09/29/2017
	PROVIOER OR SUPPLIER ID NURSING AND RE	HABILITATION		906 T	ET AOORESS, CITY, STATE, ZIP COOI HOMPSON STREET LAND, VA 23005	<u> </u>	09/29/2017
(X4) IO PREFIX TAG	(EACH OEFICIENC)	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE APP OEFICIENCY)	OLLOBE	IX5  COMPLETION TE DATE
F 2 <b>2</b> 1	started. 2. Resider have the potential tresidents in the fact residents were found 3. Staff members to corporation's) policity restraints, resident behaviors. Employ at no time under and to be secured to expedical doctor. The services of design (times) a week X 2 month to ensure of in-serviced on reside Findings of audits to (quality assurance 2 months alson (side assessments as not 2/13/2017." Credit	man and an investigation was not that reside in this facility to be physically restrained. All illity were checked and no not to be physically restrained. The best of the educated on (name of y and procedure around abuse and dealing with rees have been instructed that my circumstances are residents quipment unless indicated by a ne DCS (director of clinical ee will conduct audits 5X weeks and then 1X week X 1 per mance. Staff will be dent abuse monthly. 4. The object of the deal of the discussed during QAPI performance improvement) X between the plant of the plant the facility was found to be in	F				
		ion was provided prior to exit.					
-	COMPLAINT DEFI	CIENCY					
F 223 S <b>S</b> =D	PAST NON-COMP 483.12(a)(1) FREE ABUSE/INVOLUN	FROM	F	223			
	neglect, misapprop and exploitation as includes but is not	ne right to be free from abuse, riation of resident property, defined in this subpart. This limited to freedom from ht, involuntary seclusion and					·

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		& MEDICAID SERVICES			(	OMB NO	<u>). 093</u> 8-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY
		495362	B. WING			0.	C 9/2 <b>9/20</b> 17
NAME OF I	PROVIDER OR SUPPLIER			\$T	REET ADDRESS, CITY, STATE, ZIP CODE	_10;	012912011
ASHLAN	ID NURSING AND RE	HABILITATION		90	6 THOMPSON STREET		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				_ A	SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CDRRECTION SHOUL (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	IX51 COMPLETION DATE
F 223	Continued From pa	age 22	F 2	223			
,	any physical or che treat the resident's	emical restraint not required to symptoms.					
		lity must- pal, mental, sexual, or physical nishment, or involuntary					
		NT is not met as evidenced					-
	Based on observation document review, course of a complate determined that the resident was free from the course of the course o	ition, staff interview, facility clinical record review and in the aint investigation, it was a facility staff failed to ensure a rom abuse for one of 34 rvey sample, Resident #1.			Past noncompliance: no plan of correction required.		
	Resident #1 was in	nappropriately restrained to a an evaluation or monitoring on					
	The findings includ	le:					
	3/28/16. Resident were not limited to: blindness. Resider (minimum data set assessment with a date) of 8/4/17, cookills for daily decisimpaired. Section totally dependent of	dmitted to the-facility on #1's diagnoses included but repeated falls, dementia and nt #1's most recent MDS), a significant change in status n ARD (assessment reference ded the resident's cognitive sion making as severely G coded Resident #1 as being of one staff with transfers, ng, eating and personal					- - -
	Review of Residen reveal any assessr	t #1's clinical record failed to nents regarding physical nt #1's comprehensive care					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495362	B. WING				C /29/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	25/2011
		LABITITATION			06 THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		Α	SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROV (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BY FULL PREFIX MUST BY FULL PREFIX (EACH DEFICIENCY MUST BY FULL PREFIX MUST BY FULL PREFI		PROVIDERS PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 223	presented with beh feces, attempting to assistance and complan failed to document for the feet of the	age 23 29/16 documented the resident aviors such as playing with a stand/transfer without an action to stand/transfer without an action to stand/transfer without an action to stand the stand stand			ELI IOLENOT,		
	Virginia Department and Certification or date: 2/10/2017. In Incident type: (an Date of Director of Clinical the ties and assess to be in no acute diameters. The immediately susperattending to (name Resident was assessed to the ties and assess to the incident of Clinical the ties and assess to be in no acute diameters. The immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immediately susperattending to (name Resident was assessed to the immed	rted incident) submitted to the at of Health Office of Licensure in 2/10/17 documented, "Report incident date: 2/10/2017. X' beside) Allegation of escribe incident, including in taken: The Director of Clinical d to the secured unit this (certified nursing assistant) the said resident (Resident #1) thair with the ties of a blanket ok of the wheelchair. The Services immediately released sed the resident and found him istress, no bruises or skin he Director of Clinical Services and the Nurse of Resident #1). The essed by the Medical Director bund to be in no acute distress					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		LTIPLE CONSTRUCTION (X3) OATE SURVEY COMPLETED
		495362	B. WING	C 09/29/2017
NAME OF	PROVIDER OR SUPPLIER		T	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION				906 THOMPSON STREET ASHLAND, VA 23005
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
F 223	Social Services ha #1) and he is at ba suffered no distres continue to monitor affects (sic) as we final report will be of days and sent to your The final report sull Licensure and Cerdocumented, "This Facility Reported In office on February (name of Resident a 66 y/o (year old) diagnoses: Hyperte Repeated Falls, Dedisturbances. He I cognitively impaire for mental status) so 2017, the Director to the secured unit (name of Resident fastened to the bac Director of Clinical	bruising or skin issues noted. s assessed (name of Resident seline and he appears to have s from this incident. We will r the resident for adverse complete a full investigation. Acompleted within 5 working	· -	223

to be in no acute distress, no bruises or skin changes noted. The Director of Clinical Services immediately suspended the CNAs and the Nurse attending to (name of-Resident #1). The resident was assessed by the Medical Director of the facility and found to be in no acute distress and no observable bruising or skin issues noted. Social Services has assessed (name of Resident #1) and he appears to have suffered no distress from this incident. CNA (name) was suspended, CNA, (name) was suspended. CNA, (name) was suspended and LPN (licensed practical nurse)

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOF MR N	RM APPROVED 10. 0938-0391
	T OF OEFICIENCIES DF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) C	DATE SURVEY COMPLETED
		495362	B. WING				C
NAME OF	PROVIOER OR SUPPLIER			STR	EET AOORESS, CITY, STATE, ZIP COOE		09/29/2017
ASHLAN	ND NURSING AND RE	HABILITATION			THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES  Y MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION]	IO PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR( OEFICIENCY)	LORE	(X5) COMPLETION DATE
F 223	The Town of Ashlar contacted and Patr with report number Staff were conduct CNA that cared for fastened the ties of Resident #1's) whe evidence above, th and (name of CNA of CNA) has also be Nursing. The center (name of Resident intervene according or concerns, please Multiple observation conducted during the was with the resident was with the resident of concerns regardentified.  On 9/27/17 at 11:05 conducted with CN #9, an employee we 2/10/17. CNA #9 sesident #1 was not CNA #9 stated she director of clinical stayed with Reside untied the restraint director of clinical stated the front of a resident's lap and the stated the stated the resident stated the stated the resident stated the stated the resident's lap and the stated t	age 25 Inded pending investigation. Ind Police Department was of Officer (name) responded (number). Interviews with ed to reveal that (name) is the (name of Resident #1) and if the blanket to (name of elchair. Based on the e allegation was substantiated has been terminated. (Name een reported to the board of er will continue to monitor #1) related to this incident and gly. If you have any questions e don't hesitate to contact me."  Ins of Resident #1 were the survey. A one on one sitter and during each observation, ding a physical restraint were to a.m. an interview was A (certified nursing assistant) orking on Resident #1's unit on tated on 2/10/17 she noticed for moving and was tied up, got another CNA who got the ervices while she (CNA #9) and #1. CNA #9 stated she a little while waiting for the ervices. When asked to dent #1 was tied up, CNA #9 was in a wheelchair. CNA #9 was in a wheelchair. CNA #9 is sheet was covering the he back of the sheet was round the resident and the	F 2	23			

back of the wheelchair.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	MAPPROVED
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) OA	D. 0938-0391 TE SURVEY
		495362	B. WING				С
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		EET ACCRECA COMMANDE	0.5	9/29/2017
	D NURSING AND RE			906	EET AOORESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	OPE	(X5) COMPLETION DATE
F 223	Continued From pa	age 26	F 2	23			
	Attempts to contac	t the other staff working on	, _	20			
	Resident #1's unit	on 2/10/17 were conducted					
	during the survey. for interview.	The staff were not available			-		
	ioi iiileiview.						
		p.m. an interview was -					
İ		M (administrative staff			•		
		irector of nursing/clinical stated on the morning of					· -
	2/10/17 a CNA call	ed her to come to Resident					
		stated when she got to the unit					
		tting upright in a wheelchair hat was going on. ASM #2					
	stated Resident #1	had a blanket around his					
		motioned for her to look at the					
		hair. ASM #2 stated Resident wheelchair. ASM #2 stated					
		esident, completed a full body	•				
	assessment, a pair	n assessment and started an					
	~	#2 stated she called the					
		e unit, called the police, notified sure and Certification, and					
-		t's physician and responsible					
		ed no one admitted to					
		around Resident #1 but based she identified the CNA that					
		ly responsible, terminated the -					
		he CNA to the department of					
		ASM #2 stated she also use in-service with staff.					-
	On 9/27/17 at annr	oximately 6:00 p.m. ASM #1					
		ctor/administrator) and ASM #2					
	were made aware of	of the above concern.					
	The facility policy tit	led, "Resident Abuse"					
=	documented, "It is i	nherent in the nature and 🥏 🐔					}
		dent at The Company that basic human rights, including					

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY CDMPLETED
		495362	B. WING _		C 09/29/2017
ASHLANE	RDVIDER OR SUPPLIER  O NURSING AND REI			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
	mistreatment, exploimisappropriation of of the facility recognestablishes the folloand procedures to pestablish a disciplin fair and timely treat	from abuse, neglect,		23	

A restraint four-point plan of correction dated 2/10/17 documented, "1. A resident was physically restrained to his wheelchair with a blanket by a staff member. The resident was immediately released and assessed by Nursing Staff: MD/RP (medical doctor/responsible party) and the authorities were immediately notified. Notification was sent to APS (adult protective services) Ombudsman and an investigation was started. 2. Residents that reside in this facility have the potential to be physically restrained. All residents in the facility were checked and no residents were found to be physically restrained. 3. Staff members to be educated on (name of corporation's) policy and procedure around restraints, resident abuse and dealing with behaviors. Employees have been instructed that at no time under any circumstances are residents to be secured to equipment unless indicated by a medical doctor. The DCS (director of clinical services) or designee will conduct audits 5X (times) a week X 2 weeks and then 1X week X 1 month to ensure compliance. Staff will be

in-serviced on resident abuse monthly. 4. Findings of audits to be discussed during QAPI

charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of

property..."

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FORM APPROVED
OMB NO 0038 0301

CENTER	S FOIL MEDIONINE		<del></del>						MR NO	<u>. 09</u> 38-0391	1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1): PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBERS	(X2) MUL A. BUILD		NSTRUCT	ION	<del></del>	-		TE SURVEY MPLETED	
		495362	B. WING						09	C /29/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRES	S, CITY,	STATE, ZIP	CODE	1 00	LOILOIT	$\dashv$
					HOMPSO		•	,			ı
ASHLANI	D NURSING AND RE	HABILITATION	1								
				ASIII	LAND, VA						1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH	CORREC REFEREN	TIVE ACTION	ORRECTIO ON SHOULI HE APPROP ')	D BE	(X5) COMPLETION DATE	
F 223	Continued From pa	age 28	F2	223							
	2 months alson (side assessments as ne 2/13/2017." Credib was reviewed and compliance during		,								
	•	tion was provided prior to exit.				• •					
-	COMPLAINT DEFI			**							
F 246 SS=D	:	SONABLE ACCOMMODATION	Fí	246							
Parket a service and a service	483.10(e) Respect a right to be treated including:	and Dignity. The resident has d with respect and dignity,			F246						-
	the facility with rear resident needs and do so would endan resident or other resident or other resident or other resident or other resident or other resident or other resident review, is staff failed to ensure resident bathrooms on the later of the bathrooms for metal pull string to measured 4 inches	reside and receive services in sonable accommodation of d preferences except when to ager the health or safety of the esidents.  INT is not met as evidenced ation, staff interview, and facility it was determined that facility re access to call bells in s for two of 14 resident Hanover station unit.  Trooms 300 and 301, had a the call bell system that in length and was not e toilet or floor for resident use			1.	in Harbeen String inche pull sthat the resid	nover Si replace that m s from station t is acce toilet o	bells  00 and 3  tation had with Feasures  the measures  to the floor  if floor  if des	ave PVC 555 etal loor rom		
1	ii aesii cali leeded.										

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					(	FO 1 BMC	RM APPROVED NO. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1). PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	(X2) MUI A. BUILO		(X3)	OATE SURVEY COMPLETED			
		495362	B. WING	i					C .
NAME OF I	PROVIOER OR SUPPLIER		<u> </u>	ST	REET AOO!	RESS, CITY, STA	TE. ZIP COOE	<del></del>	09/29/2017
	o Lubania Andres	La Dil Imagrica				ON STREET			
ASHLAN	ID NURSING AND RE	ABILITATION		AS	HLAND,	VA 23005			}
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		(EA	ROVIOER'S PLAI CH CORRECTIVE S-REFERENCEO OEFIC	ACTION SHOUL	LO BE	(X5) COMPLETION DATE
F 246	Continued From pa	-	F	246	2.		have bee		
	bathrooms for room on the Hanover Sta to the call bell syste length. The call be string attached to the bathrooms on the unext to the toilet bur call bell system was	p.m., observation of the n 300 and 301 was conducted ation unit. The metal pull string arm measured 4 inches in a list did not have a long nylon the metal string, like the other unit. The call bell system was a was barely accessible. The salso placed four feet above cessible from the floor.			_	Call bells reviewed Maintenand and or Des	g accessibl oor or toile have bee by th	e t. n e or .	
	conducted with OS the maintenance di the call bell string s "These call bells ar OSM #12 stated tha	a.m., an interview was M (other staff member) #12, rector. When asked how long hould be, OSM #12 stated, e missing the nylon string." at the call bell string needs to or so that if a resident falls,				access bathroom.	in the	eir -	# 4 <sup>2</sup> .
	they are able to rea asked if a resident metal pull string fro "No." OSM #12 stathese bathrooms with call bell. OSM attach a nylon string On 9/28/17 at 5:00 staff member) #1, til director and ASM #.	ch it from the floor. When would be able to reach the m the floor, OSM #12 stated, ted that he was not aware that ere missing the nylon string to #12 stated that he would gright away.  p.m., ASM (administrative ne administrator/executive 2, the DON (Director of vices, were made aware of	ener		3:	or designo current f bathroom being	inistrator a ee re-educa acility staff n call bell co assessable ompliance v ent.	on ords to	
		led, "Call Bell System address the above concerns.			٠				. · · · · · · ·

No further information was obtained prior to exit.

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1): PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION A. BUILOING \_ COMPLETEO C 495362 B WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION Ю (X4) IO |X5} (EACH OEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG TAG DATE OEFICIENCY) F 248 · Continued From page 30 F 248 4. The Administrator and F 248 483.24(c)(1) ACTIVITIES MEET F 248 or designee to conduct SS=E INTERESTS/NEEDS OF EACH RES Quality Monitoring of (c) Activities. bathroom Call Bell cords for accessibility. Quality . (1) The facility must provide, based on the comprehensive assessment and care plan and monitoring the preferences of each resident, an ongoing conducted 3X a week program to support residents in their choice of activities, both facility-sponsored group and per week for 4 weeks to individual activities and independent activities. ensure compliance and designed to meet the interests of and support the then 1X a week per physical, mental, and psychosocial well-being of each resident, encouraging both independence month and then and interaction in the community. Quarterly thereafter. This REQUIREMENT is not met as evidenced by: Quality monitoring Based on observation, staff interview, facility schedule to be modified documentation review; and clinical record review. based on findings of it was determined that facility staff failed to provide person-centered activities for two of 34 Quality Reviews. The residents in the survey sample, Residents #12 results of the Quality and #15. Reviews. The results of 1. The facility staff failed to provide personthe Quality Monitoring centered, individualized activities as per Resident #12's preferences documented on the significant to be reviewed at the change MDS (minimum data set) assessment monthly Quality with an ARD (assessment reference date) of Assurance Performance 4/10/17. Improvement (QAPI)

2. The facility staff failed to provide activities as per Resident #15's preferences as documented

on the admission MDS (minimum data set) with

and in the social worker's notes of 12/19/16.

an ARD (assessment reference date) of 10/10/16

review.

further

meetings for

5. November 14, 2017

recommendations.

and

analysis

PRINTED: 10/12/2017

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES						NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1,¥-PROVIOER/SUPPLIER/CLIA IDENTIFICATION N⊎MBER&	(X2) MUL A. BUILC		CONSTRUCT	ION		OMPLETED
		495362	B. WING					C
NAME OF I	PROVIOER OR SUPPLIER		٠	STF	REET AOORES	SS, CITY, STATE, ZIP COOE		09/29/2017
ASHLAN	D NURSING AND REI	HABILITATION		906	THOMPSON	NSTREET		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		(EACH	VIOER'S PLAN OF CORRECTOR ACTION SHOTH ACTION SHOTH ACTION SHOTH APPROPRIES OFFICIENCY)	ULO BE	(X5) COMPLETION TE DATE
F 248	Continued From pa	ae 31	E,	248				
	The findings include	-	1 2	240	F248			
	1 The facility staff (	failed to provide person	_		1.	Resident #12 and	1 15′c	
	centered, individual #12's preferences of change MDS asses 4/10/17.  Resident #12 was a 8/12/15 with diagnolimited to enlarged	failed to provide person lized activities as per Resident documented on the significant asment with an ARD of admitted to the facility on prestate; heart failure, muscle	· · · · · · · · · · · · · · · · · · ·		J.	have been re-ass and have been pro- person cer activities. The	sessed ovided ntered MDS, Social	-  - 
	(chronic obstructive Resident #12's mos set) was a quarterly (assessment refere Resident #12 was compaired in cognitive on the BIMS (Brief exam. Resident #1 dependence on one locomotion on the unextensive assistant personal frygiene.	roidism, dementia, and COPD or pulmonary disease). It recent MDS (minimum data or assessment with an ARD since date) of 7/11/17. It could be being severely be function scoring 03 out of 15 Interview for Mental Status) 2 was coded as requiring total or staff member with dressing, and the from one staff member with	٠.	-		updated.	* .	
	assessment with ar under Section F "Pr Routine and Activitic Important" for Resid around animals suc news, do things with outside to get fresh Further review of Se "Somewhat Importa	#12's significant change MDS in ARD of 4/10/17, documented references for Customary es," that is was "Very dent #12 to listen to music, be thas pets, keep up with the in groups of people, and to go air when the weather is good ection F revealed that it was ant" for Resident #12 to us services or practices.						

Resident #12 was observed lying in his bed in his room on the following dates and times: 9/26/17 at

PRINTED: 10/12/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			. (	IRORI NA RIMC	MAPPROVED <u>). 0938-0</u> 391
	OF OEFICIENCIES OF CORRECTION	(X1):_PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LE CONSTRUCT	(X3) DA	TE SURVEY	
		495362	B. WING		<u></u>	0.	C 9/29/2017
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION	!	STREET ADORES 906 THOMPSOI ASHLAND, VA		_ 1 _ 0:	3/29/2017
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRO (EACH	VIOER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO OEFICIENCY)	OBF	(X5) COMPLETION OATE
F 248	10:05 a.m., 11:30 a and 2:15 p.m.  Review of Resident 8/19/17 documenter Resident is on 1:1 president will be visional times. The sident will be visional times and in congruent with resident with resident and very resident conversational times. The sident is now on (department). Resident is now on (department). Resident is thereby activity staff. Resident is now on reality orientation, as	age 32 p.m., 9/27/17 at 7:38 a.m., a.m., 12:20 p.m., 12:45 p.m., at #12's activity care plan dated ad the following: "Focus: program for activities. Goal: lited by activity assistant 2-3x Interventions: Encourage OOR independent activities dent abilities and interests. are and observe gestures, erbal responses and actions. on and reality orientation  at #12's activity note dated ad the following: "Annual- 1:1 program with activity dept. dent spends a lot of time in his y visited 2-3 x per week by lent is provided hydration, and conversation. Resident (times) per week by	F 248		Current residents in been re-evaluated the Activities Dire and are offered percentered activity. Updated Act preferences have be reviewed by Administrator and residents have been assessed and proviperson-centered activities. The Machine Care Plan and So Work notes have be updated.	by ctor son-ties. ivity been all reded	
• - •	conducted with OS activities director. Obeen the activity director the facility. When a completing the activity OSM #2 stated that what each resident what 1:1 activities r #2 stated that one to	p.m., an interview was M (other staff member) #2, the OSM #2 stated that she had rector for a month and a half at asked the purpose of vity MDS assessment and care plan for each resident, the goal was to get an idea of wanted to do. When asked meant on the care plan, OSM to one activities were for those of like to leave the room or		•			

who are cognitively impaired and cannot

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1): PROVIOER/SUPPLIER/CLIĄ	(X2] MUI	TIPLE CO	DNSTRU	CTION	(X3) DATE SURVEY	
ANO PLAN O	F CORRECTION	IDENTIFICATION NUMBER	A. PUILO			<del></del>	COMPLETEO	
		495362	B. WING	:			С	
NAME OF 6	PROVIOER OR SUPPLIER	100002	D. 17114C				09/29/2017	
INVINE OF L	-NOVIOLN ON SUFFLIEN					ESS, CITY, STATE, ZIP COOE		
ASHLAN	D NURSING AND RE	ABILITATION .				ON STREET		
		/		ASH	LAND,	VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		(EAC	ROVIOER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOUL( S-REFERENCEO TO THE APPROP OEFICIENCY)	DBF COMPLETI	ION
F 248	Continued From pa	de 33	<b>E</b> (	248	3	The Administrator ar		
		activities. When asked what	F.	240	J.			
		sident #12 liked to do, OSM				or designee re-educate	d .	
		vas not familiar with every				the Activity staff o	in	
		sistants knew their residents				Person- Centere		
	well. Resident 12's	activity logs were requested.				A set tets		
	0.00747						·e	
		oximately 5:10 p.m., OSM #2				compliance wi	:h	
	presented Resident	. #128 activity logs.				person-centered		
	Review of Resident	#12's "Record of One-To-One	ē .	-		activities. Th	Δ	
		st and September 2017		*		Ad1-1-2		
	documented the foll						•	
						designee re-educate		
		ion of activity: Lunch.				MDS, Activity Staff ar	d .	
		n/Response: Alert. Time Spent				Social Work staff of	n	
	20 m (minutes).	on of activity: TV, check in.				care planning proces		
		n/Response: Waking up,						
	excited. Time Spent					MDS process and Soci		
		on of activity: Lunch.				Work notes policy b	У	
		/Response: Alert, ready to				October 19, 2017.		
•	eat Time Spent: 15							
		tion of activity: TV, Movie, Reaction/Response: relaxed,				•		
	alert. Time Spent 10							
		tion of activity: ADL (activities					·	
	of daily living)/help.					·		
		calm, appreciative. Time				•		
		en en en en en en en en en en en en en e					<del>-</del>	
		tion of activity: check in, Reaction/Response: Happy,	-			·		
	ok: Time Spent: 5 (r			÷				
		on of activity: lunch, TV						
		e: Hungry. Time Spent: 15						
	(m)						* * *	- 1
		on of activity: ADL care.						1
	Resident's Respons	e: Thankful. Time Spent: 10						

PRINTED: 10/12/2017

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1)- PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBERS	(X2) MUI A. BUILE		CONSTRUCTION	(X3) D,	O. 0938-0391 ATE SURVEY DMPLETED
		495362	B. WING	·		n	C 9/29/2017
NAME OF P	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	512512011
ASHLAN	D NURSING AND RE	HABILITATION			THOMPSON STREET HLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	·IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	DBF	[X5] COMPLETION DATE
	On 9/27/17 at 5:10 conducted with OSI was considered an her assistant goes i socialize with the re consider lunch an a considered ADL care shoul activity and that star with ADL care. Whethe television as an her staff are watchinalso socializing with would consider televasked why Residen 9/8/17, OSM #2 star the same thing. Os always check behinthey are documenting residents. When as are also CNAs who stated, "No." When Resident #12's care of his likes and dislit centered, OSM #2 splan was generic an what Resident #12. I care plan OSM #2 process of re-doing them individualized. ever got out of bed if stated that she was was responsible for to attend an activity "We are responsible"	p.m., further interview was M #2. When asked if lunch activity, OSM #2 stated that if in to assist with lunch and esident, then she would activity. When asked if she rean-activity, OSM #2 stated ld not be considered an iff should always be assisting en asked if she considered activity, OSM #2 stated that if ing the television with him and in Resident #12, then she vision an activity. When it #12's activities stop at ted that she was wondering if M #2 stated that she doesn't in the asked if her activity assistants work the floor, OSM #2 oSM #2 was asked if it is plan provided a good picture kes and was resident stated Resident #12's care and you wouldn't be able to tell liked to do by looking at his stated that she was in the activity care plans to make when asked if Resident #12 to attend activities, OSM #2 not sure. When asked who ensuring a resident was able of choice, OSM #2 stated, a for telling nursing that we		248	4. The Administrator an or designee to conduct Quality Monitoring of Person-Centered car activities, care plate process, MDS procest and Social Work note Quality Monitoring to be conducted 3X a week per week for 4 weeks ensure compliance are then 1X a week per wee	et of e n ss ss. co ek to	
	"We are responsible						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB N	NO. 0938-0391
	OF OEFICIENCIES F CORRECTION	(X‡). PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		ONSTRUCTION	(X3) C	DATE SURVEY COMPLETED
		495362	B. WING				C 09/ <b>2</b> 9/2017
NAME OF P	ROVIOER OR SUPPLIER		<u> </u>	STRE	EET AOORESS, CITY, STATE, ZIP COOE		09/29/2017
					THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION			ILAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OFFICIENC)	TEMENT OF OEFICIENCIES  / MUST BE PRECEOED BY FULL  SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR OEFICIENCY)	JLO BE	JX5J COMPLETION DATE
F 248	Continued From pa	· iae 35	F 5	248			
	can't get them out	•					
	staff member) #1, director/administra (Director of Nursing aware of the above The facility policy ti documents in part, the right to attend a their choice. A daily involvement both in settings will be mai Therapeutic Recre Procedure: Reside and participate in a However, residents or participate in an wishesThe facility accommodate an i equipment, and che facility, expect the individual or othe facility, expect the individual or othe endangered. A receinvolvement will be Therapeutic Recreform should be corea. Daily activity recemonth.  b. Extra lines are a additional program c. Utilize the participate in duraterly document with should be keep to the second of these sheets are with quarterly document should be keep to the second of t	or, and ASM #2, the DON g)/clinical services, were made			quarterly thereaft Quality Monitori schedule to be modifi based on findings Quality reviews. T results of the Qual	ng ed of he ity he ce PI)	

PRINTED: 10/12/2017 FORM APPROVED

1		& MEDICAID SERVICES	·			01	VIB NO	. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT	E SURVEY MPLETEO
		495362	B. WING	i				С
NAME OF	PROVIDER OR SUPPLIER		1		EET AOORESS, CITY, STATE, ZIP	6005	09/	/29/2017
ACULAN	D MUDCING AND DE	UADII ITATIONI			THOMPSON STREET	COOE		
ASELAN	D NURSING AND RE	HABILITATION			LAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULO IE APPROPF		(X5) COMPLETION DATE
F 248	Continued From pa	ae 36	_					· <u></u>
		tion was presented prior to	F:	248				
·	per Resident #15's on the admission M an ARD (assessme	failed to provide activities as preferences as documented IDS (minimum data set) with ant reference date) of 10/10/16 orker's notes of 12/19/16.		- -	,			
	10/3/16 with diagno limited to: seizures,	admitted to the facility on ses that included but were not schizophrenia, kidney nigh blood pressure and			e e e e e e e e e e e e e e e e e e e			
-	with an ARD of 7/7/ having scored a 13 interview for mental was cognitively inta-	OS, a quarterly assessment, 17 coded the resident as out of 15 on the BIMS (brief status) indicating the resident ct to make daily decisions. oded as requiring assistance ivities of daily living.			·-		·	
	ARD of 10/10/16 in listening to music at practices as being v #15.	al MDS assessment with an the activities section coded and participating in religious very important to Resident					•	
	assistance with her resident prefers to li to get out of bed wit appointments outsid does not watch much listening to the radio	resident continues to require activities of daily living. The e in her bed and does not like the exception of going to le of the facility. The resident the television, but enjoys especially gospel music. veral gospel compact discs						

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X31 DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X41ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION I TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY** F 248 Continued From page 37 F 248 by gospel artists such as (names of artists) etc. The resident has made a request that those particular artists play continuously on her cd player." Review of the resident's care plan initiated on 10/13/16 and revised on 4/5/17 documented. "Focus. The resident is independent for activities. cognitive stimulation, social interaction r/t (related to) Resident wishes not to participate. Interventions, Music." An observation was made on 9/26/17 at 4:45 p.m. of Resident #15. The resident was lying in bed awake and calling out. There was no music or television on in the room. An observation was made on 9/27/17 at 11:55 a.m. of Resident #15. The resident was lying in bed awake. There was no music or television on in the room. An observation was made on 9/27/17 at 12:20 p.m. of Resident #15. The resident was lying in bed. Staff were in with the resident. There was no music or television on in the room. An interview was conducted on 9/27/17 at 2:45 p.m. with OSM (other staff member) #7, the director of social services. When asked about resident's preferences for activities, OSM #7 stated, "Well, during out care plan meeting we should discuss it (activity preferences)." When asked to review the social worker's note\_of 12/19/16 regarding Resident #15's request to

have the gospel music playing at all times and if that would be on the care plan, OSM #7 stated, "Yes, I should care plan that." When asked to review Resident #15's activities care plan

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938 0301

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				1U1 A DMO	KM APPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(×3) E	O. 0938-0391 DATE SURVEY COMPLETED
		495362	B. WING				C
NAME OF F	PROVIOER OR SUPPLIER		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP COL	<u> </u>	09/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906	THOMPSON STREET	, <b>L</b>	
(X4] ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	IX5J COMPLETION DATE
F 248		ent's request, OSM #7 stated,	F 2	148			
	An interview was cop.m. with OSM #1, When asked the ro "We are looking to keeping them (their them feel comfortal asked how resident obtained, OSM #1 sthat scores them (the five. We put it in the and I follow it."  A review of the active 9/26/17 for Resident television and music was no documentate gospel music player offered to participate.  An interview was cop.m. with OSM #2, 1 asked the goal of act stated, "To get an id want to do." When a #15's September 20 stated that someone attention to it and the resident's activities. When asked if it was	enducted on 9/27/17 at 4:40 the activities co-director. le of activities, OSM #1 stated, enhance quality of life, residents) oriented, making one. Keep them active." When 's activity preferences were stated, "We have an MDS list the preferences) from one to ecomprehensive care plan wities log for 9/1/17 through at #15 documented that the cower on every day. There also that the resident was the in religious services.  Inducted on 9/27/17 at 4:50 and the director of activities. When activities for residents, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of activity log, OSM #2 asked to review Resident of the were "somewhat generic." simportant that residents and were important to them,					
	in Activities" docume the right to attend a	y's policy titled, "Participation ented, "Policy: Residents have nd participate in activities of ure: 4. The facility, to the					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ANO PLAN OF CORRECTION (X3) OATE SURVEY IOENTIFICATION NUMBER: A. BUILOING COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (EACH OEFICIENCY MUST BE PRECEOED BY FULL PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) F 248 Continued From page 39 F 248 F252 extent possible, will accommodate an individual's 1. In room 300 the drawer needs..." has been replaced in the On 9/28/17 at 7:28 a.m. ASM (administrative staff cabinet used to contain member) #1, the administrator/executive director, was made aware of the findings. the resident's clothes. The toilet paper rack to No further information was provided prior to exit. hold toilet paper was F 252 483.10(e)(2)(i)(1)(i)(ii) F 252 SS=E SAFE/CLEAN/COMFORTABLE/HOMELIKE replaced in bathroom **ENVIRONMENT** 300. In room 301a the (e)(2) The right to retain and use personal handle to the upper possessions, including furnishings, and clothing. drawer of the bedside as space permits, unless to do so would infringe end table was replaced. upon the rights or health and safety of other residents. In room 301b the two large gouges behind the §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike base of the bed were environment, including but not limited to receiving repaired. The toilet treatment and supports for daily living safely. paper rack in 301's The facility must providebathroom was replaced. (i)(1) A safe, clean, comfortable, and homelike The ceiling tiles for environment, allowing the resident to use his or her personal belongings to the extent possible. bathroom 302 and room 304 (shared bathroom) (i) This includes ensuring that the resident can receive care and services safely and that the ceiling tiles were physical layout of the facility maximizes resident replaced. The independence and does not pose a safety risk. baseboard in room 308b

or theft.

(ii) The facility shall exercise reasonable care for

the protection of the resident's property from loss

This REQUIREMENT is not met as evidenced

were

paper

replaced.

repaired

holder

replaced in bathroom

was

The toilet

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>	·	0	MB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING	ii		C
NAME OF I	PROVIDER OR SUPPLIER		<del>'                                    </del>	\$T	REET AOORESS, CITY, STATE, ZIP COOE	09/29/2017
	e uuroilla Alis DE	LIADU ITATION		Į.	6 THOMPSON STREET	
ASHLAN	ID NURSING AND RE	HABILITATION	1	]	SHLAND, VA 23005	
(X4) IO	SUMMARY ST/	ATEMENT OF OEFICIENCIES	<u>1</u> ID			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	PREFI TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP OEFICIENCY)	) BE COMPLETION
F 252	Continued From pa	age 40	F2	252	200	
	•	tion, staff interview, and facility			308 aпd room 30	96
		it was determined that facility			(shared bathroom) an	d ·
•		tain a clean, comfortable and			the call bell cord wa	is
		ent for 6 of 16 resident rooms ation unit, 4 of 14 resident			replaced. The window	w
		Hanover Station unit, and 1 of			blind was replaced i	
	3 shower rooms, u	nit one.			room 311. In room 31	
	1 The facility staff	failed to maintain the Hanover			the drawer wa	
		ean homelike manner as			replaced in the cabine	-
	follows:				used to contain th	
		wer was missing from the ntain the residents' clothes.				
		room 300 was missing a toilet		• .	residents clothes an	d
	paper rack to hold	toilet paper.			the blinds wer	e
		d (the first bed), the handle to			replaced and th	<del>-</del>
ļ		of the bedside end table was bed (the second bed), two large			bedside table end tabl	e
		rved behind the base of the			to B bed's know wa	is
		for room 301 was missing a			replaced on the secon	d
	toilet paper rack to The bathroom for re	room 302 and Room 304			bottom drawer in roor	n
ł	,	, was observed to have a			310. The ceiling tile wa	is
	ceiling tile that was stain on the tile.	buckling with a brown water			replaced near th	
		d (the second bed), the	•		bathroom door on th	
	baseboard to the w	/all was pulled back exposing			outside of the bathroor	
		ue behind the second bed. The 308 and room 306 (shared			in room 330. The drie	• •
		ssing a toilet paper rack to hold		-	up brown feces in roor	<del>-</del>
		e call bell cord appeared to be			310b behind the be	
	brown in color.	indow was observed to have				
	missing blinds.	ildor was observed to liave				-
	in room 310, a drav	wer appeared to be broken	•			•
		sed to contain the residents'			gloves and towels in th	
	- •	were observed to be broken; ad table to the second (B) bed,	•		sink in shower room o	п
		h on the second (bottom)			unit 1 were removed.	

was missing a knob on the second (bottom)

		AND HUMAN SERVICES & MEDICAID SERVICES							FORI	M APPF	2/2017 ROVED 8-0391
	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILOI	TIPLE CONSTR	RUCTIO	N	_		(X3) OA	TE SUR MPLETE	VEY
		495362	B. WING				<del></del>		09	C 9/29/20	017
	PROVIOER OR SUPPLIER  D NURSING AND REI	HABILITATION		STREET AC 906 THOM ASHLANI	PSON	STREET	TATE, ZIP CO	DOE			
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION	IO PREFI) TAG	K (E CRI	EACH C	ORRECTI EFERENCI	AN OF COR VEACTION EO TO THE A ICIENCYJ	SHOULD	BE		(X5) PLETION DATE
F 252	observed on a ceiling on the outside of the 2. Dried up brown fobserved on the wasecond bed (B-bed Station unit.	ate room), a water stain was ng tile near the bathroom door le bathroom.  Teces like substance was all behind the headboard of the ) in room 301 on the Hanover	F 2	52	2.	reside paper drawe walls,	stands, to nts cloth racks, t ers, large ceilin	coning, to nandle gouge g t	tain oilet to es in iles,		
<u> </u>	3. The unit one sho	wer room was observed with					oards,				-

The findings include:

1. The facility staff failed to maintain the Hanover Station unit in a clean homelike manner.

On 9/26/17 at 1:15 p.m., observation of the Hanover Station (dementia) unit was observed. Room 300 was the first room observed. In room 300 a drawer was missing from the cabinet used to hold the resident's clothes. The bathroom for room 300 had marks on the wall from where the toilet paper rack used to be. There was no toilet paper rack in the bathroom. There was no toilet paper in the bathroom.

Room 301 was the second room to be observed. The end table next to the first bed had a broken handle on the top drawer. Two large gouges were observed behind the second bed. The first gouge measured approximately 18 inches long and the second gouge measured approximately 15 inches long. The bathroom to room 301 was missing the center piece to the toilet paper rack to hold the toilet paper roll. There was no toilet paper in the bathroom.

- cords, blinds, dried up feces, shower rooms have been reviewed by the Administrator and all have been replaced, repaired or cleaned.
- 3. The Administrator and or designee re-educated current staff

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OLMILI	(O ) OI (II)EDIO) II (E	I CHARLESTONIA CENTIONE	· · · ·			<u></u>	MR NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			DNSTRUCTION		(X3) OATE	
	<u></u>	495362	B. WING	;			00/2	; !9/2017
	ROVIOER OR SUPPLIER D NURSING AND RE	HABILITATION		906 T	ET AOORESS, CITY, STATE HOMPSON STREET LAND, VA 23005	, ZIP COOE	1 03/2	.9/2017
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCEO 1 OEFICIE	ACTION SHOUL( O THE APPROP	) RE	(X5) COMPLETION DATE
F 252	bathroom between conducted. The bath a ceiling tile that was stain on the tile.  On 9/26/17 at 1:25 was conducted. The observed pulled bath glue on the dry wall baseboard that was by the bedside end 308 that was share a toilet paper rack, the call bell was conducted. The call bell was conducted. The sections where slated on 9/26/17 at 1:28 310 was conducted. The sections where slated on the drawer should broken. A gap was the drawer should residents window the missing and broken next to the second next to the knob.  On 9/26/17 at 1:32 made of Room 330	p.m., observation of the room 302 and 304 was athroom was observed to have as buckling with a brown water p.m., observation of room 308 he baseboard to the wall was ack exposing dry wall and old I behind the second bed. The spulled back was kept in place I table. The bathroom for room ad with room 306 was missing. The nylon string attached to vered with a brown substance.  p.m., observation of room 311 he blinds to the window had ts were missing.  p.m., an observation of room d. A cabinet drawer used to tots' clothes appeared to be observed in the cabinet where have been sitting. The bolind was observed with a hole p.m., an observation was 0. A water stain was observed at the bathroom door on the	F	252	Environmental En	aining a Honoment to ation is a maintained. Administrate signee to come observation of the term observation of the term of the	ensure ttained or and conduct tions of racks to paper, andle to ouges in tiles, Il bell n spots, dried up all, dirty	
	conducted with OS	a.m., a walk through was M (other staff member) #12, irector. When asked how			·			

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			1	FOR NODAC	RM APPROVED
	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER;	(X2) MU A. BUILO		ONSTRUCTION	(X3) D	O. 0938-0391 DATE SURVEY OMPLETED
		495362	B. WING	·			C )9/29/2017
NAME OF	PROVIDER OR SUPPLIER	-		STRE	ET AODRESS, CITY, STATE, ZIP CODE		912912017
ASHLAN	ID NURSING AND RE	HABILITATION		906 T	THOMPSON STREET LAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	O BE	IX5  COMPLETION OATE
F 252	resident rooms, bar OSM #12 stated the time, but it also depreported needed fix that if something nonursing staff would maintenance book OSM #12 stated the needed constant methat maintenance reback due to their cuand in the main din the also does weekled it was difficult to see that if he sees anythe need to be replaced on "homework" she	walked the building to see if throoms etc. needed repairs, at he walks the building all the bended on what nursing ting to him. OSM #12 stated seeded to be fixed on the unit, log this information into the on a repair requisition form. at the Hanover Station unit aintenance. OSM #12 stated epairs sometimes get pushed urrent renovations on unit one ing room. OSM #12 stated that y audits of the building but that a every room. OSM #12 stated hing during the audits that d, he will put this information ets and try to make repairs as	F	252	sink. Quality monitor to be conducted 3X week per week for weeks to ensi compliance and then a week per month a then quarte thereafter. Qua monitoring schedule be modified based findings of qua reviews. The results	( a very and and and and and and and and and and	
	asked about the res #12 stated that he had p company in to replate stated that he had p corporate for new for tried ordering from a OSM #12 stated the was placed on hold stated that the process from the restated that the cabin 1988 and that he control to the restated that the cabin 1988 and that he control that the cabin 1988 and that he control that the cabin 1988 and the cabin 1988 and the ca	erved with OSM #12. When sidents' cabinet drawer, OSM has been trying to get a ace all cabinets. OSM #12 but in a request in with urniture but he accidentally an un-approved company. Process for ordering furniture due to that reason. OSM #12 less for being approved for lso placed on hold because cilities in Florida that needed ent hurricane. OSM #12 nets in room 300 were from auld not find parts for them.			the quality monitoned to be reviewed at monthly quality assurance performation improvement (Quality meetings for reviewed)	ring the ality nce API)	

room 300. When asked if he could tell what was missing, OSM #12 stated, "The toilet paper holder. That might of went missing yesterday. I

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	RM APPROVED 10. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
		495362	B, WING				C
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		9/29/2017
ASHLAN	D NURSING AND RE	HABILITATION			THOMPSON STREET ILAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	NUD RE	X5  COMPLETION OATE
F 252	Continued From pa wasn't aware of it."	_	F	252			
	gouges behind the with spackle. OSM rounds yesterday a room to see what r stated, "I made a copy of his list, OS one down. I fixed it looked at the resid OSM #12 stated th bathrooms. This w bathroom for room the center piece for missing. OSM #12 the Hanover Statio piece from the toile OSM #12 stated the toilet paper holders not aware of the m 301. OSM #12 state of the water stain of bathroom shared by	erved with OSM #12. The second bed were patched up #12 staled that he made afternoon and went room to needed repair. OSM #12 quick list." When asked for a M #12 stated, "I didn't write this on the fly." When asked if he ent's bathrooms' yesterday, at he did not look at the writer took OSM #12 into the 301. OSM #12 confirmed that if the toilet paper rack was a stated that the residents on n unit always take the center of paper rack and lose them at he is always replacing the second of the own of the ceiling tile of the own on 302 and 304.					
	with OSM #12. The the wall behind the place. OSM #12 co baseboard of the woosm #12 stated the baseboard was made aware of it uosm #12 was ther room 308. When a string attached to the #12 stated, "white."	a.m., room 308 was observed be baseboard to the bottom of second bed was put back into primed that he had seen the vall folded up and had fixed it, at he was not sure how long is folded back but he was not ntil he made rounds yesterday, in taken into the bathroom of asked what color the nylon he call bell should be, OSM "When asked what he noticed ing, OSM #12 stated that the					

cord was brown and needed to be replaced. OSM

		AND HUMAN SERVICES			Pi	ZINIE	D: 10/12/20	17
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	FOR M.R. Ni	MAPPROVE 0.0938-03	ΞD
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D	O. 0936-03 ATE SURVEY DMPLETED	91
	······································	495362	B. WING			_	C 9/29/2017	
NAME OF F	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		3123120 11	$\dashv$
ASHLAN	D NURSING AND REI	HABILITATION		i	6 THOMPSON STREET SHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETIC OATE	NC
F 252	Continued From pa	ge 46	F2	252		-		
	interview was cond staff member) #1, t director. ASM #1.s (Office of Licensure renovations were go	eximately 1:00 p.m., an outed with ASM (administrative the administrator/executive tated that she made the OLC and Certification) aware that bring on at this time and the ess. A copy of the letter was					- -	-
	renovations docume to inform you of ren (Name of facility) or 2017. The construct wallpaper and repair and repairting the remailpaper in the Lot painted. On our Unicarpet will be remove repainted. In addition	sent to the OLC about the ented the following: "I wanted ovations that will begin here at a tomorrow September 20, etion crew will be removing the ring a portion of the sheetrock main dining room. The oby will be taken down and t 1, the wallpaper and the red from the walls and will be a, we are replacing all of the ter-we will be replacing them						
	The above letter did concerns.	not mention the above		-	·			
	staff member) #1, the director, and ASM #	o.m., ASM (administrative the administrator/executive 2, the DON (Director of vices, were made aware of						
	No further information A policy could not be	on was presented prior to exit. e provided.						
·- , · <del>-</del>	2. Dried up brown fe observed on the wal	ces like substance was I behind the headboard of the						

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	). 0938-0391
	OF DEFICIENCIES OF CDRRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	3		ONSTRUCTION	(X3) OA	TE SURVEY MPLETEO
		495362	B. WING	i		0.5	С
NAME OF F	PROVIOER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP COOE	_ 1 09	/29/2017
					THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		I.			}
				ASI	LAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES  Y MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	II O RE	(X5) COMPLETION DATE
F 252	Continued From pa	age 47	F	252		_	
	•	) in room 301 on the Hanover	•	-0-			-
	On 9/26/17 at 1:20	p.m., observation of room 301					
	was conducted. To observed behind the	vo large gouges were e second bed. While ges in the wall; this writer					-
		and dried up brown feces like		-			
		the wall behind the headboard					
	of the bed.						
	•	e e of the					
		p.m., a second observation 301. Dried up brown-feces					
		ained stuck to the wall behind					
	the headboard of the						. :
	On 9/26/17 at 4:10	p.m., an interview was					<u> </u>
		A (certified nursing assistant)					
		now often CNAs made rounds					
		oms, CNA#12 stated, "Every					
		ked what Resident #12 looks					
		CNA #12 stated that she	٠, ٠٠		•		
		ients and looks at the poms. When asked when the					
		nto room 301, CNA#12 stated					
		)1 at approximately 3:30 p.m. noticed anything unusual in					
		stated, "No." CNA#12					
		into room 301. When asked					•
		ehind the head board of the					
		12 stated, "That looks like BM					
		It looks very old and dry."					
	When asked why fe	eces on the wall is a concern,					
		t feces on the wall was					
		12 then took a paper towel and					
j		from the wall. CNA#12					
	alerted a housekee disinfect the area.	per that was across the hall to					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE	* & MEDICAID SERVICES	<del></del>			OMB	VO. 0938-0391
	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		495362	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADORESS, CITY, STATE, ZIP COD	<u> </u>	09/29/2017
BOUL AND	O AUTODINO AND DE	LIABU (TATION)			THOMPSON STREET	<i>,</i> _	
ASHLAN	D NURSING AND RE	HABILITATION			LAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AP OEFICIENCY)	HOULD BE	IXS) COMPLETION OATE
F 252	Continued From pa	age 48	ES	252			
		p.m., an interview was	1 2	.02			
		M (other staff member) # 13,					
		director. When asked how					•
		g made rounds in resident					
		entia unit, OSM #13 stated that nded on resident rooms at leas:					
		the dementia unit. OSM #13	L		•		
		to round at least every hour.		,	•		
		he checked while rounding,					
		at he checked rooms, floors, cleanliness. OSM #13 also			•		
		om received a deep cleaning					
	on certain days of t	the weeks. When asked if				•	
		cleaning included checking	-	•			
r		he beds, OSM #13 stated that check behind the beds and he				•	
		erneath the beds. A copy of					3
	the deep cleaning s	schedule was requested.					!
	On:0100147 at anne	avimataly 6 a m. the deep					
		oximately 6 p.m., the deep was presented. Room 301					
	received a deep cle						
	·						
		p.m., ASM (administrative					
	staff member) #1, t	tor and ASM #2, the DON					
		g)/clinical services, were made					
	aware of the above	concerns. No further		-			
	information was pre	esented prior to exit.					
			•		- 1	-	
	3. The unit one sho dirty gloves and tov	ower room was observed with wels in the sink.	·				
	shower rooms was 4:10 p.m., the Wing	p.m., observation of the conducted. On 9/16/17 at g One shower room was wels and used gloves was	-				

observed in the sink of the shower room.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MR M	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
	:	495362	B. WING				C 9/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADORESS, CITY, STATE, ZIP COOE	1	19/29/2017
					THOMPSON STREET		
ASHLAN	D NURSING AND REI	ABILITATION	<u></u> .		HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OFFICIENCY)	DRE	IX5) COMPLETION DATE
F 252	Continued From pa	ge 49	F2	252			
	conducted with CN. #13. When asked cleaned, CNA #13 were supposed to compare the conduction of the conduction of the conducted with CN.	p.m., an interview was A (certified nursing assistant) when the shower rooms were stated that the nursing aides clean the shower rooms after CNA #13 stated that nursing		·	-		
	dirty linens and tow to the dirty linen bar trash should also be taken to the trash b	n the shower chairs and place els in a trash bag to be taken rel. CNA #13 stated that bagged separately and in immediately after a shower as ever ok to leave trash and			·		
	linen in the sink of t stated that it was no tell this writer what room, CNA #13 sta be."; CNA #13 imme	he shower rooms, CNA #13 ot. When asked if she could was in the sink of the shower ted, "Something that shouldn't diately placed or gloves and					
	sink@When asked room was used, CN been that morning.	owels and gloves from the when the last time the shower to \$\text{IA} #13 stated that it must have CNA #13 stated that she had \$\text{\text{at 3}} p.m. for evening shift.	- -				
	staff member) #1, to director/administrate	or and ASM #2, the DON )/clinical services, were made					
<u>.</u>	documents in part, promote and encou soiled linen is consi contaminatedPropre-rinse soiled line Perform hand hygie linen into bad (caref	led, "Handling of soiled linen" the following: "Policy: To rage the concept that all dered the cedure: Do not sort or in the resident areas. The pon Gloves, Place dirty fully, not to touch outside of s, perform hand hygiene,	-				

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILDING COMPLETEO C 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AODRESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION IX5| COMPLETION (EACH OFFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **OEFICIENCY**) F 252 Continued From page 50 F 252 secure plastic bag, place bag in designated barrel in hallway or soiled utility room. Perform hand hygiene." F 279 483.20(d);483.21(b)(1) DEVELOP F 279 SS=D COMPREHENSIVE CARE PLANS F279 483.20 (d) Use. A facility must maintain all resident The comprehensive assessments completed within the previous 15 plan for vision care months in the resident's active record and use the results of the assessments to develop, review which triggered and revise the resident's comprehensive care plan. section V. on the CAA (care area assessment) 483.21 of the admission MDS (b) Comprehensive Care Plans (minimum data (1) The facility must develop and implement a with an ARD comprehensive person-centered care plan for each resident, consistent with the resident rights (assessment reference set forth at §483.10(c)(2) and §483.10(c)(3), that date) of 5/8/17 has includes measurable objectives and timeframes been developed to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident #2. The care comprehensive assessment. The comprehensive plan for resident #9 has care plan must describe the following been updated for vision (i) The services that are to be furnished to attain which triggered in or maintain the resident's highest practicable section V on the CAA physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and summary of the 4/26/17

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not

provided due to the resident's exercise of rights

under §483.10, including the right to refuse

treatment under §483.10(c)(6).

set)

admission/5-day

data

(minimum

assessment.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0301

			1				<u> 1M DIM</u>	<u>J. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC				(X3) DA	ATE SURVEY OMPLETED
	<u>.                                    </u>	495362	B. WING				0:	C 9/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	ETADE	DRESS, CITY, STATE, ZIP CODE		
ASHLAN	D NURSING AND RE	HABILITATION				PSON STREET , VA 23005		
	CHI MADV OTA	TEMENT OF DEFICIENCIES		7.0				<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(E/	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPRO DEFICIENCY)	IDBE	IX5) COMPLETION DATE
F 279	Continued From pa	age 51 I services or specialized	F	279	2.	MDS has reviewed mos	-	
		ces the nursing facility will				MDS assessments fo	vr.	
	provide as a result					current residents an		
		If a facility disagrees with the				ensured CAA's tha		
		ARR, it must indicate its ident's medical record.				_		
							е	
	` '	with the resident and the			2	planned appropriately.		· · · · · ·
	resident's represen	itative (s)			3.	The Administrator an		
	(A) The resident's	goals for admission and				or Regional MD		÷
	desired outcomes.	J. T				Consultant re-educate	.d	
	(B) The resident's (	preference and potential for				the MDS staff o	n	
1		acilities must document				compressive MD	)S	
		nt's desire to return to the				assessments ar	ıd	•
		sessed and any referrals to cies and/or other appropriate				Comprehensive car	re	
	entities, for this pur					plans to ensur	re	
	(C) Discharge plan	s in the comprehensive care				compliance is attaine	∍d	
ļ		e, in accordance with the				and maintained.		٠.
-	requirements set for	orth in paragraph (c) of this			4.	The Administrator ar	ıd	-
	section.	NT is not met as evidenced	-			or designee to condu	ct	
	by:	TI IS NOT THE US CVIDENCED	-			quality monitoring	of	
		erview, facility document review				the completed MDS f	or	
		review, it was determined that ed to develop a comprehensive		-		30 days to		
		f 34 residents in the survey				comprehensive MI	DS .	
	sample, Residents	#2 and #9.				•	all	
	1 The facility staff t	failed to develop Resident #2's				current residents and		
	comprehensive car	e plan for vision which				CAA's that triggered a		
		V. on the CAA (care area						
		admission MDS (minimum RD (assessment reference				all care plann	zu	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				Ω	FURN MR NC	). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTI	ion	(X3) DA	TE SURVEY. MPLETED
		495362	B. WING					C
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRES	SS, CITY, STATE, ZIP CODE	1 09	/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906	THOMPSON	N STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH	VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULT REFERENCED TO THE APPROP DEFICIENCY)	) RE	(X5) COMPLETION DATE
F 279	Continued From pa	age 52	F	279				
	#9 for Vision, which CAA summary of the MDS (minimum date)  The findings included the fi	failed to develop Resident #2's re plan for vision which V. on the CAA (care area admission MDS (minimum RD (assessment reference)  dmitted to the facility on 5/1/17 tincluded but were not limited munodeficiency virus), ion, difficulty swallowing and ol. The most recent MDS ), a quarterly assessment, with ent reference date) of 8/8/17 as rarely or never being able rs or to be understood. The dias requiring assistance from				monitoring to conducted 3X a way per week for 4 week ensure compliance then 1X a week month and to quarterly thereafter. Quality monito schedule to be modified based on findings quality reviews. The results of the quantity is assurated to the monitoring to reviewed at the monitoring quality assurated performance improvement (Quality for reviewed at the monitoring to reviewed at the monitoring	s to and per hen ring fied of The ality be thly	
	Review of Residen	would be developed. t #2's care plan initiated on ence a vision plan of care.			5.	November 14, 2017		·

An interview was conducted on 9/28/17 at 9:15

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OI	JE NO	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONS	STRUCTION		(X3) DATE	U938-U391 E SURVEY PLETED
		495362	B. WING	·				
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE	710.0005	09/	29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906 THO	MPSON STREET ND, VA 23005	:, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD TO THE APPROPI	BE.	(X5) COMPLETION OATE
F 279	MDS coordinator. Very care plan, LPN #1 show the whole team. When asked the property was triggered on the assessment, LPN # that's a cue to your #1 was asked to retthe 5/8/17 admission care plan for a vision. "There isn't one (vision asked if there shout LPN #1 stated, "Year efference the MDS MDS assessment, for sident	nsed practical nurse) #1, the When asked the purpose of the stated, "Basically to map out in cares for that resident." occess staff followed if an area e CAA of the MDS to put it on the care plan." LPN view Resident #2's CAA from on MDS assessment and the on plan of care. LPN #1 stated, sion plan of care)." When ld be a vision plan of care, s." When asked what staff followed to complete an LPN #1 stated, "The RAI		279	DEFICIE	:NGY)		
	meet the resident's	medical, nursing, and mental eeds that are identified in the						
	No further informati	on was provided prior to exit.					•	•
-	Williams and Wilkin documented, "A write communication tool members that helps	mentals of Nursing Lippincott s 2007 pages 65-77 tten care plan serves as a among health care team sensure continuity of care plan is a vital source of						

information about the patient's problems, needs,

## DEPARTMENT OF HEALTH AND HUMAIN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

			T			NAIR IAC	<i><u>). 0938-039</u>1</i>
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY DMPLETEO
		495362	B. WING			05	C 9/2 <b>9/201</b> 7
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ASHLAN	ID NURSING AND REI	HABILITATION		906 T	THOMPSON STREET HLAND, VA 23005		!
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F 279	and goals. It conta achieving the goals and is used to direc revise and update t	sins detailed instructions for s established for the patient ct careexpect to review, the care plan regularly, when in condition, treatments, and	F:	279			
		of Nursing Lippincott Williams pincott Company Philadelphia	· _				· · · · · · · · · · · · · · · · · · ·
	#9 for Vision, which CAA summary of the MDS (minimum data A/19/17 with the dia altered mental state disorder, borderline depression, anxiety stroke, and catarace (Minimum Data Set with an ARD (Asses 7/27/17. Resident amoderately impaired decisions, scoring a BIMS (Brief Intervier The resident was coassistance for bathicating and ambulation transfers; and as control of the communication of the communicatio	failed to care plan Resident in triggered in section V on the ne 4/26/17 Admission/5-day ta set) assessment.  Idmitted to the facility on agnoses of but not limited to: us, dementia, delusional expersonality disorder.  If chronic kidney disease, ets. The most recent MDS to was a quarterly assessment resement Reference Date) of #9 was coded as being the in ability to make daily life as 9 out of a possible 15 on the ew for Mental Status) exam. The oded as requiring extensive ing; supervision for hygiene, tion; as independent for continent of bowel and bladder.	-				
<u>-</u> .	admission MDS ass 4/26/17.	ical record revealed the sessment with an ARD of - Area Assessment (CAA)					

Summary, the resident was triggered in Column A

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 279 Continued From page 55 F 279 (Care Area Triggered) and was to be care planned as evidence by an "X" in Column B (Care Planning Decision) for the areas of: 02. Cognitive Loss/Dementia, 03. Visual Function, 05. ADL Functional/Rehabilitation Potential, 07. Psychosocial Well-Being; and 12. Nutritional Status. A review of the care plan failed to reveal any evidence the area of "03. Visual Function", as being care planned. Resident #9 had a diagnosis of cataracts. On 9/28/17 at 8:55 a.m., in an interview with LPN #1 (Licensed Practical Nurse, the MDS nurse) she stated that if it is triggered, then it should be care planned unless it was specifically documented that it would not be. LPN #1 stated she did not know if the cataracts for Resident #9 were causing her any impairment but that it was a potential for them to become visually significant. When asked about a facility policy for care planning from the CAA triggers, LPN #1 stated the facility uses the RAI manual (Resident -Assessment Instrument). On 9/28/17 at 5:20 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey. F 280 483.10(c)(2)(i-ii,iv,v)(3),483:21(b)(2) RIGHT TO F 280 SS≈E PARTICIPATE PLANNING CARE-REVISE CP

(c)(2) The right to participate in the development and implementation of his or her person-centered

plan of care, including but not limited to:

483.10

		I VIAD LIGINIVIA SEVAICES			F	TRINIED: 10/12/201
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			^	FORM APPROVE
S TATEMEN A NO PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	[X2) MUL A. BUILOI	TIPLE CONSTRUCTIONS	DN	MB NO. 0938-039 (X3) OATE SURVEY COMPLETED
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A CUI A A	ID BUIDONIO AND DE	Habit Paris.		906 THOMPSON	STREET	
AOILLA	ND NURSING AND RE	HABILITATION		ASHLAND, VA		
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F 280	including the right to be included in the prequest meetings a revisions to the per (ii) The right to part expected goals and amount, frequency, other factors related plan of care.  (iv) The right to receincluded in the plan (v) The right to see right to sign after sign of care.  (c)(3) The facility shright to participate in shall support the resplanning process m  (i) Facilitate the included in the plan included in the resplanning process m	cipate in the planning process, o identify individuals or roles to planning process, the right to and the right to request son-centered plan of care.  icipate in establishing the doutcomes of care, the type, and duration of care, and any dout the effectiveness of the eive the services and/or items of care.  the care plan, including the gnificant changes to the plan stall inform the resident of the plan his or her treatment and sident in this right. The ustusion of the resident and/or tive.	F 2	F280 1.	plan has been upon with altercations. October 2016 thromoder March 2017. The plan for resident has been updated include the residindividual accordences. Resident has care plan for infection has resolved. Residence with the plan updated related to fall that occurred April 20, 2017.	from ough care #15 d to ent's tivity ident eye been ident was the on
	(iii) Incorporate the	esident's personal and			plans for altercation	ns in

483.21

cultural preferences in developing goals of care.

(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

the past 12 months for

all current residents and

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY IOENTIFICATION NUMBER: A. BUILOING COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION IO (EACH OFFICIENCY MUST BE PRECEOSO BY FULL PRÉFIX PREFIX (X5) (EACH CORRECTIVE ACTION SHOULO BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION COMPLETION TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 280 Continued From page 57 F 280 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-updated as indicated. (A) The attending physician. Activity staff has re-(B) A registered nurse with responsibility for the assessed current residents (C) A nurse aide with responsibility for the activity preferences and resident. those preferences have (D) A member of food and nutrition services staff. been added to current care plans. Infections (E) To the extent practicable, the participation of the resident and the resident's representative(s). that have resolved have An explanation must be included in a resident's been resolved on the medical record if the participation of the resident current residents care and their resident representative is determined not practicable for the development of the plans. Falls that have resident's care plan. occurred in the past 12 (F) Other appropriate staff or professionals in months to have disciplines as determined by the resident's needs interventions or as requested by the resident. documented on care (iii) Reviewed and revised by the interdisciplinary plan

assessments.

by:

team after each assessment, including both the

This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the plan of care for four of 34 residents in the survey sample, Residents #11, #15, #12 and #10.

comprehensive and quarterly review

current

of

residents.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

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### F 280 Continued From page 58

- 1. The facility staff failed to review and revise Resident #11's care plan following multiple resident to resident altercations from October 2016 through March 2017.
- 2. The facility staff failed to update Resident #15's activities plan of care to include the resident's individual activity preferences.
- 3. The facility staff failed to resolve Resident #12's care plan for an eye infection, after the resident's eye infection had cleared on 6/11/17.
- 4. The facility staff failed to review and revise Resident #10's comprehensive care plan following a witnessed fall that occurred in April 20, 2017.

#### The findings include:

1. The facility staff failed to review and revise Resident #11's care plan following multiple resident to resident altercations from October 2016 through March 2017.

Resident #11 was admitted to the facility on 9/9/15. Resident #11's diagnoses included but were not limited to: Huntington's disease (1), history of falling and difficulty swallowing. Resident #11's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/22/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #11's clinical record and facility reported incidence reports submitted to the

- F 280
- 3. The Administrator and or designee has reeducated the MDS on care planning altercations. care planning infections and care planning falls. The Administrator and or designee has reeducated the Activity staff on updating care plans to include the residents individual activity preferences.
- 4. The Administrator and or designee to conduct quality monitoring of Quality care plans. monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring

PRINTED: 10/12/2017

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	OF DEFICIENCIES OF CORRECTION	(X1)_ PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) D	O: 0936-039 ATE SURVEY DMPLETED
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NAME OF	NAME OF PROVIDER OR SUPPLIER ASHLAND NURSING AND REHABILITATION			STREET ADDRESS. O	ET ADDRESS, CITY, STATE, ZIP CODE		9/29/2017
ASHLAN	D NURSING AND RE	HAB)LITATION	] :	906 THOMPSON ST ASHLAND, VA 2:	TREET	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORREC RRECTIVE ACTION SHO ERENCED TO THE APP DEFICIENCY)	OH! D BE	IX5] COMPLETION DATE
F 280	and Certification reresident altercation  - 10/17/16: Resident halfway and pushe floor. Resident #1' supervision and mowas assessed and -2/4/17: Resident # another resident # another resident # another resident # sitting on the floor top of her eye. Reson one supervision resident was asses -3/21/17: Resident halfway swinging horesident inadvertent fell to the floor (and resident struck Resmultiple scratches. treated and placed indefinitely.  Review of Resident 10/25/16 failed to reviewed or revised incidents.  On 9/27/17 at 2:54 conducted with OS social services dirested in the floor social services directly.	ant of Health Office of Licensure, we aled the following resident to us involving Resident #11:  The triple was ambulating in the dianother resident down to the liwas placed on one on one conitored. The other resident treated.  End was observed lying in beed. The other resident was with blood dripping from over sident #11 was placed on one and monitored. The other	F 280	sch bas qua res mo rev qua per imp me ana rec	etings for re	ts of The uality be onthly rance QAPI) view, rther	

resident to resident altercations. OSM #7 stated, "They should be for both (residents)." OSM #7 stated the social services department and MDS department was responsible for updating residents' care plans after resident to resident

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IOENTIFICATION NUMBER: (X3) OATE SURVEY A. BUILDING \_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION OATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE **OEFICIENCY**) F 280 Continued From page 60 F 280 On 9/27/17 at 5:13 p.m. ASM (administrative staff member) #1 (the executive director/administrator) presented an action plan for care plans not being updated in a timely manner. The resolution column was blank. ASM #1 stated the action plan was ongoing. On 9/27/17 at approximately 5:30 p.m. an interview was conducted with LPN (licensed practical nurse) #1 (the MDS coordinator). LPN #1 confirmed Resident #11's care plan was not updated after each of the above incidents. LPN #1 stated a regional employee recently identified issues with residents' care plans not being updated in a timely manner. LPN #1 stated there was a current plan of correction and care plans were still being audited. On 9/27/17 at 6:10 p.m. ASM #1, ASM #2 (the director of nursing/clinical services) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Plans of Care" documented, "The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team

- (1) "Huntington's disease (HD) is an inherited

psychosocial well-being..."

disease that causes certain nerve cells in the brain to waste away. People are born with the

to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and

No further information was presented prior to exit.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING\_ COMPLETED C 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 Continued From page 61 F 280 defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements. clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/querymeta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=huntingtons+disease & ga=2.104416073.876861010.1506957357-139 120270.1477942321 2. The facility staff failed to update Resident #15's activities plan of care to include the resident's individual activity preferences. Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney disease, diabetes, high blood pressure and stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/7/17 coded Resident #15 as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

important to Resident #15.

Review of the annual MDS assessment with an ARD of 10/10/16 coded listening to music and participating in religious practices as being very

Review of the social worker's note dated 12/19/16

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 Continued From page 62 F 280 documented, "The resident continues to require assistance with her activities of daily living. The resident prefers to lie in her bed and does not like to get out of bed with the exception of going to appointments outside of the facility. The resident does not watch much television, but enjoys listening to the radio; especially gospel music. The resident has several gospel compact discs by gospel artists such as (names of artists) etc. The resident has made a request that those particular artists play continuously on her cd player." Review of the resident's care plan initiated on 10/13/16 and revised on 4/5/17 documented. "Focus. The resident is independent for activities, cognitive stimulation, social interaction r/t (related to) Resident wishes not to participate. Interventions, Music." An observation was made on 9/26/17 at 4:45 p.m. of Resident #15. The resident was lying in bed awake and calling out. There was no music or television on in the room. An observation was made on 9/27/17 at 11:55 a.m. of Resident #15. The resident was lying in bed awake. There was no music or television on in the room. An observation was made on 9/27/17 at 12:20 p.m. of Resident #15. The resident was lying in

bed. Staff were in with the resident. There was no

An interview was conducted on 9/27/17 at 2:45 p.m. with OSM (other staff member) #7, the director of social services. When asked about residents' preferences for activities, OSM #7

music or television on in the room.

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	An interview was cop.m. with OSM #1, When asked the ro "We are looking to keeping them (them feel comfortal asked how resident obtained, OSM #1 that scores them (the five. We put it in the and I follow it." Whe include the resident #1 stated, "Yes ma" A review of the active 9/26/17 for Resider television and musi was no documentate offered to participate An interview was cop.m. with OSM #2, asked the goal of a stated, "To get an idwant to do." When a #15's September 20 stated that someon attention to it and the resident's activities When asked if it was received activities to OSM #2 stated it was #15's resident's specifications.	g out care plan meeting we activity preferences)."  Inducted on 9/27/17 at 4:40 the activities co-director. Ile of activities, OSM #1 stated, enhance quality of life, residents) oriented, making ble. Keep them active." When it's activity preferences were stated, "We have an MDS list the preferences) from one to be comprehensive care plan would it's activities preferences, OSM it's activities preferences, OSM it's activities preferences, OSM it's activities preferences, OSM it's activities preferences, OSM it's activities preferences, OSM it's activities preferences, OSM it's activities preferences, OSM it's activities for 9/1/17 through it's activities preferences.  Inducted on 9/27/17 at 4:50 the director of activities. When ctivities for residents, OSM #2 dea first of all for what they asked to review Resident it is into activity log, OSM #2 e was not really paying any interest the care plan for the were "somewhat generic." is important that residents in at were important to them, as. When asked if Resident icific preferences were care	F 2	280			
		tated that it should be.					

On 9/28/17 at 7:28 a.m. ASM (administrative staff

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NAME OF	PROVIDER OR SUPPLIER				REET AOORESS, CITY, STATE, ZIP CODE		
ASHLAN	ND NURSING AND RE	HABILITATION			6 THOMPSON STREET SHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI; TAG	x	PROVIOER'S PLAN OF CORREC [EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	JLO RF	(X5) COMPLETION OATE
F 280	An interview was ca.m. with LPN (lice MDS coordinator. Vare plans, LPN #1 needs and care we are abided by." Wh#15's annual MDS LPN #1 stated, "I dwere documented were documented."  No further informations. The facility staff #12's care plan for resident's eye infections.	dministrator/executive director, f the findings.  onducted on 9/28/17 at 11:50 nsed practical nurse) #1, the When asked why residents had stated, "To make sure their are done and their preferences asked to review Resident and the activities plan of care, id not see that her preferences on."  ion was provided prior to exit. failed to resolve Resident an eye infection, after the ction had cleared on 6/11/17.		280	OLI IOILNO1)		
	limited to: enlarged weakness, hypothy (chronic obstructive Resident #12's mo set) was a quarterly (assessment refere Resident #12 was impaired in cognitiv on the BIMS (Brief exam. Resident #1 dependence on on locomotion on the limited was the second to the limited was the second to the limited was the second to the limited was the second to the limited was the second to the limited was the second to the limited was the second to the limited was the second to the limited was the second to the second to the limited was the second to the second	prostate, heart failure, muscle prostate, heart failure, muscle political description of the pulmonary disease). It recent MDS (minimum datally assessment with an ARD ence date) of 7/11/17. Coded as being severely be function scoring 03 out of 15 Interview for Mental Status) 12 was coded as requiring total e staff member with dressing, unit, eating, and bathing; and ce from one staff member with					·

Review of Resident #12's current care plan revealed the following focus area initiated on

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

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	10 1 OK MEDICARE	A MILDICAID SERVICES			0!	MB NO	<u>. 0938-03</u> 91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	_	(X3) DAT	E SURVEY APLETED
		495362	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, S	TATE ZIR CODE	1 09	/29/2017
				906 THOMPSON STREET	•		
ASHLAN	D NURSING AND RE	HABILITATION	1				
	<u> </u>			ASHLAND, VA 23005			
(X4] ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PL	AN OF CORRECTIO	<del></del>	
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF1:	(EACH CORRECT)	IVE ACTION SHOULD	RF	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAĠ	CROSS-REFERENCI	ED TO THE APPROPI	RIATE	OATE
				DEF	FICIENCY)		
F 280	Continued From pa	ige 65	F 2	80			
	6/2/17: "Focus: The	e resident has an eye infection					
		(as evidence by)- drainage,					
		nt infection will resolve by					
		ons: Antibiotics as ordered by					
		ourage mobility. Monitor					
		drainage, fever, erythema					
	(reddening of skin)	eic.)					
	Decidence of Decidence	- #401- DOO / 1 / · · · · ·					
		t #12's POS (physician order					
		7, failed to reveal an order for	•				
	antibiotics related to	o an eye infection.					
		e 2017 POS and MAR					
		stration record) could not be					
	located in his thinne	ed record.				•	
		#12's June 2017 nursing					
		iment when the eye infection					
	had healed or resol	ved.		•			
							-
		y's infection control l <del>o</del> g					
		ent #12 had conjunctivitis on					
		on was documented as					·
	resolved on 6/11/17						
	On 9/27/17 at 11:05	a.m., an interview was	-				
	conducted with LPN	l (licensed practical nurse)					
	#10, Resident #12's	nurse. When asked who					
	was responsible for	reviewing and revising the					
	care plan, LPN #10	stated that the MDS nurses.					
	were responsible. \	When asked if that included					, i
	resolving items from	n the care plan, LPN #10		• •			
	stated, "Yes." When	n asked if Resident #12					
	continued to have a	n eye infection, LPN #10		·			ľ
		t#12 did not have an eye					
		N#10 was shown Resident					1
	#12's care plan for h	nis eye infection, LPN #10					ŀ
		I have been discontinued."					
		rpose of the care plan, LPN					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR NO NO	M APPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTION	(X3) DA	O. 0938-0391 ATE SURVEY OMPLETED
		495362	B. WING_				C
NAME DF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	_   _ 0;	9/29/2017
ASHLAN	ID NURSING AND RE	HABILITATION			THOMPSON STREET LAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D B E	(X5) COMPLETION DATE
F 280	on 9/27/17 at 11:50 conducted with LPN asked who was resplans, LPN #1 state interdisciplinary teau pdating the care p#12 continued to hastated that she wou LPN #1 was shown care plan, LPN #1 shave been resolved On 9/27/17 at apprinterview was conditated, "There is not conducted."	purpose of the care plan was for providing care.  5 a.m., an interview was N#1, the MDS nurse. When sponsible for updating care ed that the whole m was responsible for plans. When asked if Resident ave an eye infection, LPN #1 ald have to find out. When a Resident #12's eye infection stated, "It probably should d."  oximately 12:15 p.m., further ucted with LPN #10. LPN #10 a medication on the MAR.	F 28	30			
	treating an eye infe be resolved." On 9/28/17 at 5:15 staff member) #1, t	stration record) actively ction. The care plan should p.m., ASM (administrative he administrator/executive				·	n. Talu
		2, the DON (Director of rvices, were made aware of					٠
	4. The facility staff Resident #10's com following a witnesse 20, 2017.	ion was presented prior to exit.  failed to review and revise aprehensive care planed fall that occurred on Aprilational admitted to the facility on					

5/2/13 with a readmission date of 9/14/14 with diagnoses that included, but were not limited to,

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	10. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) E	DATE SURVEY COMPLETED
		495362	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER		<u></u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		09/29/2017
ASHLAN	D NURSING AND REI	HABILITATION		90	06 THOMPSON STREET SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PRDVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	IIDBE	(X5) COMPLETION DATE
F 280	Resident #10's mos set), a quarterly ass (assessment references Resident #10 as be BIMS (brief interview assessment of Resident #10 as as coded as a "3" of 15, on the BIMS #10 was severely of decision making. From the staff members for a staff me	swallowing, convulsions, ychosis.  Ist recent MDS (minimum data sessment with an ARD ence date) of 7/6/17, coded eing unable to complete the ew for mental status). The staff sident #10's cognitive status (three) out of a possible score exam, indicating that Resident ognitively impaired with daily Resident #10 was also coded ive assistance of one to two all activities of daily living and iding or understood when nothers.  In #10's progress notes the following documentation;  In Mesident had fallen from a (and) was witnessed. 0 (no) ofted. No facial grimacing sted (sic) in bed the rest of P (responsible party) called."  In #10's comprehensive care any documentation concerning p.m. an interview was		280	DEFICIENCY)		
	conducted with LPN a floor nurse. LPN responsible for revie plans following an in	N (licensed practical nurse) #3, #3 was asked who was ewing comprehensive care ncident. LPN #3 stated that ity of the DON (director of					

On 9/28/17 at 7:30 a.m. ASM (administrative staff

		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495362	B. WING		C 09/29/2017		
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		IO PREFI; TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 280	= 280 Continued From page 68  member) #1, the executive director/administrator, was made aware of the above findings. A policy regarding comprehensive care plans was requested at this time.  On 9/28/17 at 8:45 a.m. an interview was conducted with LPN #4, a floor nurse. LPN #4 was asked who was responsible for reviewing and revising the comprehensive care plan following an incident. LPN #4 stated, "I'm not sure."						

On 9/28/17 at 9:15 a.m. an interview was conducted with LPN #1, the MDS coordinator. LPN #1 was asked who was responsible in the facility for reviewing and revising the comprehensive care plans. LPN #1 stated that the IDT (interdisciplinary team) reviewed and revised the care plans. LPN #1 further stated, "An interim 21-day care plan is completed on admission and then each section is completed by the assigned discipline. Ongoing the IDT will review and revise care plans at quarterly care plan meetings and whenever there is a change such as new medications, changes in condition, falls and or other incidents. We would look at a need for new interventions and adjust the care plan accordingly. We also look at all new orders and incidents in morning meeting and address those items on the care plan at that time." When asked specifically about falls, LPN #1 stated that the care plan would be reviewed following each fall to determine whether or not new interventions are necessary." LPN #1 was asked to review Resident #10's comprehensive care plan and to state whether or not his care plan was reviewed and revised following the April 20,2017 fall. LPN #1 stated she would get back to this writer.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OAT	(X3) DATE SURVEY COMPLETEO		
	495362	B. WING	WING			C	
ROVIDER OR SUPPLIER			STRE	EET AOORESS, CITY, STATE, ZIP COOE	1 09,	29/2017	
ASHLAND NURSING AND REHABILITATION			906	THOMPSON STREET			
(X4) IO SUMMARY STATEMENT OF OEFICIENCIES PREFIX (EACH OEFICIENCY MUST BE PRECEOED BY FULL TAG REGULATORY OR LSC IOENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHO)	ULOBE	IX5) COMPLETION DATE	
On 9/28/17 at 10:30 conducted with ASM nursing/clinical services when a care plan with revised. ASM #2 streviewed at each coincidents. ASM #2 responsible for reviplans, ASM #2 state nursing can assist.'  On 9/28/17 at 11:20 writer and stated the	a.m., an interview was M #2, the director of vices. ASM #2 was asked vas to be reviewed and tated that the care plan was are plan meeting and with any was asked who was ewing and revising the care ed, "The MDS staff and " D a.m., LPN #1 returned to this at Resident #10's fall was not	F	280				
end of the survey p 483.21(b)(3)(i) SER PROFESSIONAL S (b)(3) Comprehens The services provid as outlined by the c must- (i) Meet professiona This REQUIREMEN by: Based on observat document review, a was determined tha professional standa	rocess.  EVICES PROVIDED MEET TANDARDS  ive Care Plans  led or arranged by the facility, omprehensive care plan,  al standards of quality.  NT is not met as evidenced  ion, staff interview, facility and clinical record review, it at facility staff failed to follow ards of practice for two of 34	F	281	hand palm protector apported and application is documented treatment er	plied as		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa On 9/28/17 at 10:30 conducted with ASM nursing/clinical services. ASM #2 streviewed at each caincidents. ASM #2 responsible for reviplans, ASM #2 state nursing can assist." On 9/28/17 at 11:20 writer and stated the reviewed or revised. No further information of the survey phenomenate of the	ROVIDER OR SUPPLIER  D NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69  On 9/28/17 at 10:30 a.m., an interview was conducted with ASM #2, the director of nursing/clinical services. ASM #2 was asked when a care plan was to be reviewed and revised. ASM #2 stated that the care plan was reviewed at each care plan meeting and with any incidents. ASM #2 was asked who was responsible for reviewing and revising the care plans, ASM #2 stated, "The MDS staff and nursing can assist."  On 9/28/17 at 11:20 a.m., LPN #1 returned to this writer and stated that Resident #10's fall was not reviewed or revised on his care plan.  No further information was presented prior to the end of the survey process. 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents #12	ROVIDER OR SUPPLIER  D NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69  On 9/28/17 at 10:30 a.m., an interview was conducted with ASM #2, the director of nursing/clinical services. ASM #2 was asked when a care plan was to be reviewed and revised. ASM #2 stated that the care plan was reviewed at each care plan meeting and with any incidents. ASM #2 was asked who was responsible for reviewing and revising the care plans, ASM #2 stated, "The MDS staff and nursing can assist."  On 9/28/17 at 11:20 a.m., LPN #1 returned to this writer and stated that Resident #10's fall was not reviewed or revised on his care plan.  No further information was presented prior to the end of the survey process.  483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents #12 and #2.	ROVIDER OR SUPPLIER  O NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69  On 9/28/17 at 10:30 a.m., an interview was conducted with ASM #2, the director of nursing/clinical services. ASM #2 was asked when a care plan was to be reviewed and revised. ASM #2 stated that the care plan was reviewed at each care plan meeting and with any incidents. ASM #2 was asked who was responsible for reviewing and revising the care plans, ASM #2 stated, "The MDS staff and nursing can assist."  On 9/28/17 at 11:20 a.m., LPN #1 returned to this writer and stated that Resident #10's fall was not reviewed or revised on his care plan.  No further information was presented prior to the end of the survey process.  483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents #12 and #2.	ROVIDER OR SUPPLIER  A BULLOING  A BULLOING  B. WIMS  STREET ADDRESS, CITY, STATE, ZIP CODE 905 THOMPSON STREET ASHLAND, VA 20055  SUMMARY STATEMENT OF DEFICIENCIES  EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69  On 9/28/17 at 10:30 a.m., an interview was conducted with ASM #2, the director of nursing/clinical services. ASM #2 was asked when a care plan was to be reviewed and revised. ASM #2 was asked who was reviewed at each care plan meeting and with any incidents. ASM #2 was asked who was reviewed as teach care plan meeting and with any incidents. ASM #2 was asked who was reviewed or revised on his care plan.  No further information was presented prior to the end of the survey process.  483.21(b)(3) (SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (I) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents #12 and #2.	OF OFFICIENCIES CORRECTION  (X1) PROVIDER SUPPLIER  DIVERSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 69  On 9/28/17 at 10:30 a.m., an interview was conducted with ASM #2, the director of nursing/clinical services. ASM #2 was asked when a care plan was to be reviewed and revised, aSM #2 stated, "The MDS staff and nursing can assist."  On 9/28/17 at 1:20 a.m., LPN #1 returned to this writer and stated that Resident #10's fall was not reviewed or revised on his care plan.  No further information was presented prior to the end of the survey process.  483.21(b)(3)) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (b) Meet professional standards of quality, This REQUIREMENT) is not met as evidenced by:  Based on observation, staff interview, facility cocument review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents #12 and #2.	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391	
STATEMENT DF OEFICIENCIES AND PLAN OF CORRECTION		(X1)_ PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBERS	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) DA	TE SURVEY	
					•		С	
NAME OF PROVIOER OR SUPPLIER		495362	B, WING	.=		09	9/29/2017	
			STREET ADORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET					
ASHLAND NURSING AND REHAB(LITATION		HAB(LITATION	··		ASHLAND, VA 23005			
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PRDVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TD THE APPRI DEFICIENCY)	ILD BE	IX5I COMPLETION DATE	
F 281	Continued From pa	age 70	F	28	generated for			
		eft hand palm protector was in place when it was			Resident#12 not			
	not applied on 7/27	//17.			having left hand	•		
	2. The facility staff	failed to clarify a 9/13/17			palm protector			
	physician's order fo	or a T-spot (1) laboratory			applied but			
-	specimen for Resid	lent #2.			documented.			
					LPN#10 has been			
	The findings includ	e:			counseled on not			
	1. The facility staff	documented Resident #12's			following Physicia	ı .		
left hand palm protec		ector was in place when it was			orders and			
	not applied on 7/27	7/17.			educated on			
		admitted to the facility on			following physicia	n		
		oses that included but were not prostate, heart failure, muscle			orders as indicate	j.		
		roidism, dementia, and COPD			Resident#2			
		e pulmonary disease).			laboratory reques			
		st recent MDS (minimum data y assessment with an ARD			for a T-SPOT" has			
	(assessment refere	ence date) of 7/11/17.			been obtained an	i		
		coded as being severely refunction scoring 03 out of 15			documented in th	9		
	on the BIMS (Brief	Interview for Mental Status)	-		chart accordingly.			
		2 was coded as requiring total staff member with dressing,			Resident #12			
		unit, eating, and bathing, and			currently resides i	n		
	extensive assistant	ce from one staff member with			the facility and ha	S .		
	personal hygiene.				no s/s of any			
		p.m., an observation was			adverse effects.			
		#12. He was lying in bed with e. The fingers to his left hand			Resident #2			
		htly contracted. His right hand			currently residés i	n		
	was under the cove	ers and was not visible. He			the facility and ha	S		
	was not wearing a j	palm protector to his left hand.			no s/s of any			
	On 9/27/17 at 7:38	a.m., an observation was			adverse effects.			

On 9/27/17 at 7:38 a.m., an observation was

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTER	29 LOK MEDICAKE	A MEDICAID SERVICES					UNIO INC	<u>. 0938-0391</u>	
	OF DEFICIENCIES F CORRECTION	(X1)_PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER&	(X2) MULTIPLE CONSTRUCTION  A. BUILDING					(X3) DATE SURVEY COMPLETEO	
		495362	B. WING					C 09/29/2017	
NAME OF F	PROVIDER OR SUPPLIER		-	STRE	ET ADORESS, (	CITY, STATE, ZIP CODE			
ASHLAND NURSING AND REHABILITATION				906 T ASH					
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CO	ER'S PLAN OF CORRECTI RRECTIVE ACTION SHOU ERENCED TO THE APPRO DEFICIENCY)	D BE	X5} COMPLETION DATE	
	his hands at his sic right hands appear He was not wearin his bilateral hands.  On 9/27/17 at 10:0 made of Resident; his hands at his sic right hands appear He was not wearin his bilateral hands.  On 9/27/17 at 12:3 made of Resident his hands at his sic appeared to be slig was under the cov was not wearing a  On 9/27/17 at 2:15 made of Resident his hands at his sic appeared to be slig was under the cov was not wearing a  On 9/28/17 at 10:3 made of Resident his hands at his sic appeared to be slig was under the cov was not wearing a  On 9/28/17 at 10:3 made of Resident left hand palm guar Review of Resident the following occur 8/22/16: "Long ter tolerate wearing right."	#12. He was lying in bed with de. The fingers to his left and red to be slightly contracted. It gas splint or palm protector to a splint or palm protector to be as a splint or palm protector to be slightly contracted. It is a splint or palm protector to be slightly contracted. It is a splint or palm protector to be slightly contracted. It is right hand ghtly contracted. His right hand ers and was not visible. He palm protector to his left hand. It is palm protector to his left hand ghtly contracted. His right hand ghtly contracted his left hand. It is and was not visible. He palm protector to his left hand. It is and was not wearing his ard or his right hand splint.  In #12's clinical record revealed pational therapy note dated and goals: Pt (patient) will ght hand splint for up to 8 hours		281			en esults		
	to prevent develop Pt will tolerate wea	ght hand splint for up to 8 hours oment of further contractures. aring left dyna-splint (type of cations (sic) or up to 8 hours per							

day."

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-03				
	OF DEFICIENCIES OF CORRECTION	IX1): PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495362	B. WING	s			C	
NAME OF I	PROVIDER DR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	29/2017	
		HABILITATION.			06 THOMPSON STREET			
ASHLAN	ID NURSING AND REI	HABILITATION		A	SHLAND, VA 23005			
(X4) ID PREFIX TAG	[EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CDRRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 281	Continued From pa	age 72	F:	281	3.Licensed Nurses re-			
	· · · · · · · · · · · · · · · · · · ·				educated by			
		ne occupational therapy notes dent #12 was discharged from	•		DCS/Designee regardi	ng		
OT services on 8/31 bilateral splints. Th		1/16 with orders for the			following Physician	_		
		ne following was documented: -serviced in donning/doffing of			orders on obtaining		•	
		ave been turned over to staff.			laboratory specimen			
		eral hand splints for up to 8			and the process in			
hours per day to prevent skin breakdown and contractures. No further OT (occupational)				following up with				
	services are indicated at this time."				laboratory results	,	-	
	Review of Resident	t #12's POS (physician order			including Physician an	d		
		e physician on 8/28/17,			RP notification. Licens	ed		
		llowing orders: "Right hand			Nurses re-educated by	<b>y</b>		
		e day, check skin once d palm protector on at all			DCS/Designee regardi	ng		
	times. May remove	for hygiene, skin checks,			following Physician	_	,	
	check placement e	very shift."			orders on application	of	• .	
		t #12's "Impaired skin integrity"			hand splints and palm			
		1/16, documented the ons: "Left hand palm protector"			protectors.DCS/Design	ne		
		hand splint as ordered."			e during		e e e e e e e e e e e e e e e e e e e	
	These interventions	s were initiated on 2/2/17.			Morning Clinical			
	Review of Resident	t #12's September 2017 TAR			Meeting to conduct			
	(treatment administ	tration record) revealed blanks			quality monitoring of			
		ler the following treatment: on during the day check skin			physician laboratory			
	once removed."	on during the day ellock \$k[l]			orders and application	ı	•	
	= 4b				of hand splints and pa	ilm		
		ie September 2017 TAR signatüres on 9/26/17 for 3-11			protectors dailyx4			
	shift and 9/27/17 for	r 7-3 and 3-11 shifts indicating			weeks, weeklyx4 and			
	that the <u>l</u> eft hand sp	olint was in place.			then monthly, PRN an			

On 9/28/17 11:05 a.m., an interview was conducted with LPN (licensed practical nurse)

as indicated.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	· <del>,                                     </del>		(	DMB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1): PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	-	DNSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495362	B. WING	<b>i</b> _		C
MAME OF I	PROVIDER OR SUPPLIER	L	I	STRE	ET AOORESS, CITY, STATE, ZIP COOE	09/29/2017
NAMEOF	-KOVIOLIKON BUILLEICH			I	HOMPSON STREET	
ASHLAN	D NURSING AND RE	HABILITATION		1	LAND, VA 23005	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO OEFICIENCY)	LO BE COMPLETION
F 281	Continued From pa	age 73	F	281		
1 20.		s nurse. When asked if		-01		
	Resident #12 was	supposed to have a splint to	•		4.Findings to be	
	his right hand and	a palm protector to his left			_	
	hand I PN #10 loo	ked at his physician's orders			communicated to	the
	and stated that he	was supposed to have splints			QAPI committee	•
	in place. When as	ked if they were in place, LPN			monthly and as	
-	#10 stated that she				mondiny and as	
					indicated, Quality	
	When asked what	initials meant on the TAR, LPN	1.		•	0.5
1		ials meant that a treatment wa	S	**:	monitoring schedul	es -
		asked why there were blanks			modified based on	
	(no signatures) for	the right hand splint on			findings	
	Resident #12's Se	ptember TAR, LPN.#10 stated,			<del>-</del>	47
	"That is supposed	to just be an FYI." When	- •		5.November 14, 20	·
	asked if it was her	initials documented on 9/27/17	•		,	•*       •
	for /-3 and 3-11 sr	nift documenting that Resident tector was in place, LPN #10				
	#12's left paint pro	en asked if his paim protector				• •
	stated, yes with	27/17, LPN #10 stated; "No. I				·4_
	orobably should be	ave circled my initials." LPN				The second of the second
	#10 stated that circ	led initials indicated that the	_			-
	treatment was not		_		*	
			<u>.</u> :			
	On 9/28/17 at 5:15	p.m, ASM (administrative 🐇				**************************************
	staff member) #1,	the administrator/executive		•		
	director and ASM	#2, the DON (Director of				
]		ervices, were made aware of				·
	the above concern	· -			•	e ,• .
1			T 11 -			<del>-</del>
	The facility policy t	itled, "Clinical/Medical	· • •			: ·- ·- ·
	Records" docume	nted in part, the following:				
		are maintained in accordance				
1	with professional p	ractice standards to provide urate information on each				
	resident for continu	ity of care "		•		<del>-</del>
	2 The facility stoff	failed to clarify a 9/13/17		•		
	physician's order f	or a T-spot (1) laboratory				
	specimen for Resi	dent #2.				

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CENTE	42 LOK MEDICAKE	A MEDICAID SERVICES				<u>_OMB</u> N	<u>O. 0938-0</u> 391
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION '		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495362	B. WING	i		0	C 09/2 <b>9</b> /2017
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STR	ET ADDRESS, CITY, STATE, ZIP CDOE		3/23/2011
				l	THOMPSON STREET		
ASHLAN	ID NURSING AND RE	HABILITATION		ı			
				ASF	ILAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	ULO BE	IX5) COMPLETION OATE
F 281	with diagnoses that to: HIV (human imr	age 74  dmitted to the facility on 5/1/17  t included but were not limited munodeficiency virus (2)), ion, difficulty swallowing and	F2	281			
	elevated cholesterd (minimum data set an ARD (assessme coded the resident term memory proble cognitively. Reside never being able to understood. The resident code and the resid	ol. The most recent MDS ), a quarterly assessment, with ent reference date) of 8/8/17 as having both short and long tems and as severely impaired ant #2 was coded as rarely or understand others or to be estioent was coded as requiring aff for all activities of daily		٠			
		lent's care plan did not s obtaining laboratory	•				
	Review of the infect 9/13/17 documents	tious disease consult dated ed, "Check T-spot."					·_ · · · · · · · · · · · · · · · · · ·
		al record did not evidence ne T-spot laboratory (lab)					↑ · · · · · · · · · · · · · · · · · ·
	a.m. documented, obtain blood draw of unable to identify the she called her superwhat type of lab neron "T-SPOT" needs cl	e's notes dated 9/14/17 at 4:30 "Lab @ (at) facility unable to due to type of order. Tech upe of blood draw from order ervisor who also does not know eded. questions what is a arification note left on 24 hr MD (medical doctor)."	-				
		e clinical record did not tation that the laboratory test with the physician.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	(X3) D/	(X3) DATE SURVEY COMPLETED	
		495362	B. WING	<b>.</b>		C 0/20/2047	
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION		HABILITATION	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		09/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TIX (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION OATE	
F 281	An interview was coa.m., with ASM (ad the director of nurs was asked when at ASM #2 stated, "It physician wants. I was asked when at ASM #2 stated, "It physician wants. I was a ware of the An interview was cop.m., with LPN (lice When asked what understand a doctor the doctor." When amount of time to costated, "Within a doctor with the common of the facility of the	ministrative staff member) #2, ing/clinical services. ASM #2 in order would be clarified. probably depends on what the would say a day." ASM #2 was findings at that time.  conducted on 9/28/17 at 12:25 ensed practical nurse) #3. staff did if they did not or's order, LPN #3 stated, "Call asked what was a reasonable call the physician, LPN #3		281			

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOING \_ COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER , STREET ADORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES PROVICER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEOED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY) F 281 Continued From page 76 F 281 HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the United States, HIV is spread mainly by having anal or vaginal sex or sharing drug injection equipment with a person who has HIV. Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV regimen) every day. ART can't cure HIV infection, but it can help people with HIV live longer, healthier lives. HIV medicines can also reduce the risk of transmission of HIV. This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/fac t-sheets/19/45/hiv-aids--the-basics F282 F 282 483.21(b)(3)(ii) SERVICES BY QUALIFIED F 282 SSEE PERSONS/PER CARE PLAN 1. Resident#12 has left hand palm (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, protector applied as as outlined by the comprehensive care plan, ordered and mustapplication is (ii) Be provided by qualified persons in documented, A accordance with each resident's written plan of treatment error care.

#6, and #7.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview, facility

document review, and clinical record review, it was determined that facility staff failed to follow

the written plan of care for six of 34 residents in

the survey sample, Residents #12, #15, #23, #2,

1a. The facility staff failed to apply Resident #12's

report has been generated for

Resident#12 not

having left hand

palm protector

applied but documented.

(	(	

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CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVE
T OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	495362	B. WING _		C
PROVIDER OR SUPPLIER	₹	_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/29/2017
ID NURSING AND RI	EHABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	LILD BE COMPLETION
b. The facility staff of care to attempt interventions prior to Resident #12 or 2. a. The facility staff written plan pressures as orde the comprehensive.  b. The facility staff written plan of care blood glucose beforthe physician's order plan.  3. The facility staff written plan of care blood glucose beforthe physician's order plan.  3. The facility staff written plan of care before each meal comprehensive can be force and meal comprehensive can (human immunode Triumeq (1) to Resthe 6/23/17 infection continue the Trium 5. The facility staff continue the Trium 5. The facility staff continue the Trium 5. The facility staff continue the Trium 5. The facility staff continue the Trium 5. The facility staff care to attempt the physician or the physician of the physician or the physician of the phys	rector and right hand splint per ers and written plan of care.  If failed to follow the written plan non-pharmacological to the administration of Ativan multiple occasions in July.  It failed to follow Resident of care for obtaining blood ared by the physician and per e plan of care.  If failed to follow Resident #15's to to monitor the resident's ore meals and at bedtime per der and comprehensive care  If failed to follow Resident #23's to obtain blood glucose levels per the physician's orders and are plan.  If failed to follow Resident #2's are plan to provide the HIVHIV-reficiency virus (2)) medication sident #2 and failed to follow ous disease doctor's order to need.  If ailed to follow Resident #6's	F 28		
	PROVIDER OR SUPPLIES SUMMARY ST (EACH DEFICIENCE REGULATORY OR REGULATOR	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495362  PROVIDER OR SUPPLIER  RD NURSING AND REHABILITATION  SUMMARY STATEMENT DF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 77  left hand palm protector and right hand splint per the physician orders and written plan of care.  b. The facility staff failed to follow the written plan of care to attempt non-pharmacological interventions prior to the administration of Ativan to Resident #12 on multiple occasions in July.  2. a. The facility staff failed to follow Resident #15's written plan of care for obtaining blood pressures as ordered by the physician and per the comprehensive plan of care.  b. The facility staff failed to follow Resident #15's written plan of care to monitor the resident's blood glucose before meals and at bedtime per the physician's order and comprehensive care	TOF DEFICIENCIES OF CORRECTION  (X1) PRDVIDERSUPPLIER  495362  PROVIDER OR SUPPLIER  ID NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 77  left hand palm protector and right hand splint per the physician orders and written plan of care.  b. The facility staff failed to follow the written plan of care to attempt non-pharmacological interventions prior to the administration of Ativan to Resident #12 on multiple occasions in July.  2. a. The facility staff failed to follow Resident #15's written plan of care for obtaining blood pressures as ordered by the physician and per the comprehensive plan of care.  b. The facility staff failed to follow Resident #15's written plan of care to monitor the resident's blood glucose before meals and at bedtime per the physician's order and comprehensive care plan.  3. The facility staff failed to follow Resident #23's written plan of care to obtain blood glucose levels before each meal per the physician's orders and comprehensive care plan.  4. The facility staff failed to follow Resident #2's comprehensive care plan to provide the HIVHIV-(human immunodeficiency virus (2)) medication Triumeq (1) to Resident #2 and failed to follow the 6/23/17 infectious disease doctor's order to continue the Triumeq.  5. The facility staff failed to follow Resident #6's	TOF DEFICIENCIES OF CORRECTION    X1) PROVIDER SUPPLIER   198362   296 THOMPSON STREET   290 THOMPSON STREET

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM OMBRIO	APPROVED
STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETED		
		495362	B. WING	)			C /29/2017
NAME OF	PROVIOER OR SUPPLIER				EET AOORESS, CITY, STATE, ZIP COOE	1 007	LSIZOTI
ASHLAN	ID NURSING AND RE	HABILITATION		l	THOMPSON STREET HLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES  Y MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	I O BE	IX5) COMPLETION OATE
F 282	Continued From pa The findings include		F	282			
	left hand palm prote the physician order  Resident #12 was a 8/12/15 with diagnor limited to: enlarged weakness, hypothy (chronic obstructive Resident #12's mosset) was a quarterly (assessment refere Resident #12 was of impaired in cognitive on the BIMS (Brief exam. Resident #1 dependence on one locomotion on the uextensive assistant personal hygiene.  On 9/26/17 at 5:15 made of Resident # his hands at his side appeared to be sligh was under the cove was not wearing a proper solution of the coverage of the personal hygiene.	failed to apply Resident #12's ector and right hand splint per s and written plan of care.  admitted to the facility on present included but were not prostate, heart failure, muscle roidism, dementia, and COPD apulmonary disease). Set recent MDS (minimum data via assessment with an ARD ence date) of 7/11/17. Coded as being severely refunction scoring 03 out of 15 interview for Mental Status) 2 was coded as requiring total restaff member with dressing, and reform one staff member with the staff member with the staff member to his left hand and was not visible. He coalm protector to his left and the staff ingers to his left hand.  The fingers to his left hand.  The fingers to his left hand.  The fingers to his left and was lying in bed with the staff ingers to his left and was lying in bed with the staff ingers to his left and was a splint or palm protector to			documented in medical record per Physicians order. Resident blood glucose is being obtained documented in medical record per Physician order. Resident currently receis all prescribed Findicated by Physician order Resident#6 is currently receis all prescribed medications as indicated by Physician order Resident#6 is currently receis all prescribed medications as indicated by Physician order.	#23 s and the as #2 is ving HIV r.	

On 9/27/17 at 10:05 a.m., an observation was made of Resident #12. He was lying in bed with

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	FORM APPROVED
STATEMENT	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1		CONSTRUCTION	MB NO. 0938-0391 (X3) OATE SURVEY COMPLETEO
		495362	B. WING			C 09/29/2017
NAME OF	PROVIOER OR SUPPLIER				EET AOORESS, CITY, STATE, ZIP COOE	1 OSIZSIZOTI
ASHLAN	ND NURSING AND RE				THOMPSON STREET HLAND, VA 23005	
JX4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI) TAG	×	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULC CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	J. R.E. CONSILETION
F 282	right hands appeared He was not wearing his bilateral hands.  On 9/27/17 at 12:38 made of Resident # his hands at his sid appeared to be slig was under the cover was not wearing a proper of the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared of Resident # left hand palm guared. Review of Resident sheet) signed by the documented the following intervention as ordered. Right his bilateral plan dated 8/3 following intervention as ordered. Right his sidney was not wearing a propeared with the propeared was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was not wearing a propeared to be slig was not wearing a propeared to be slig was not wearing a propeared to be slig was not wearing a propeared to be slig was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propeared to be slig was under the cover was not wearing a propea	de. The fingers to his left and red to be slightly contracted. g a splint or palm protector to 5 p.m., an observation was #12. He was lying in bed with de. The fingers to his left hand phtly contracted. His right handers and was not visible. He palm protector to his left hand. p.m., an observation was #12. He was lying in bed with de. The fingers to his left hand phtly contracted. His right handers and was not visible. He palm protector to his left hand phtly contracted. His right handers and was not visible. He palm protector to his left hand. O a.m., an observation was #12. He was not wearing his rd or his right hand splint.  It #12's POS (physician order-re physician on 8/28/17, llowing orders: "Right hand e day, check skin once d palm protector on at all for hygiene, skin checks, very shift."  It #12's "Impaired skin integrity" 1/16, documented the ons: "Left hand palm protector and splint as ordered."		82	Resident#6 is blood glucose is being obtained and documented in the medical record as per Physician order.Resident#7 is currently receiving all prescribed medications as indicated by Physician order. Resident#7 blood glucose is being obtained and documented in the medical record as per Physician order. Resident#12 currently resides in the facility and has no s/s of adverse effects. Resident#15	
		were initiated on 2/2/17.				·

Resident #12's most recent "Nursing Tech Information Kardex" documented the following:

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CENTER	<b>₹S FOR MEDICARE</b>	& MEDICAID SERVICES				FURI OMB NO	0.0938-0391
	OF DEFICIENCIES F CORRECTION	X1  PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	I		LE CONSTRUCTION	(X3] DA	O. 0938-0391 ATE SURVEY OMPLETED
		495362	B. WING	i <u> </u>			C 9/29/2017
NAME OF P	PROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE		3/23/2017
ASHLAN	D NURSING AND RE	HABILITATION		9	906 THOMPSON STREET ASHLAND, VA 23005		
(X4] ID PREFIX TAG	(EACH DEFICIENCY	RTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY]	IDRE	[XS] COMPLETION OATE
F 282	Kardex failed to me protector to his left Review of Resident (treatment administ (no signatures) und "Right hand splints once removed."  Further review of the revealed initials or shift and 9/27/17 for that the left hand spurpose of the care purpose of the care purpose of the care for providing care of who had access to that nurses such as DON (director of nu access to the care phad acce	nd/palm protectors." The ention Resident #12's palm hand.  It #12's September 2017 TAR tration record) revealed blanks der the following treatment: on during the day check skin the September 2017 TAR signatures on 9/26/17 for 3-11 or 7-3 and 3-11 shifts indicating plint was in place.  I.m., an interview was N (licensed oractical nurse) is nurse. When asked the entire plan, LPN #10 stated that the entire plan was to serve as a guide on each resident. When asked the care plan, LPN #12 stated is the MDS nurse, floor nurses, cursing) and unit manager had plan. When asked if CNAs care plan, LPN #10 stated that ang Kardex that was updated en asked if Resident #12 was a splint to his right hand and a is left hand, LPN #10 stated that a reatment was completed. In or sure. When asked what a treatment was completed. In or sight hand splint on Resident AR, LPN #10 stated, "That is	F 2	282		3	
		e an FYI." When asked if it					

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CENTER	3 FOR WEDICARE	A MEDICAID SERVICES			OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495362	B. WING		C 09/29/2017
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHLAND NURSING AND REHABILITATION			İ	906 THOMPSON STREET	
				ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION

### F 282 Continued From page 81

was her initials documented on 9/27/17 for 7-3 and 3-11 shift documenting that Resident #12's left palm protector was in place, LPN #10 stated, "yes." When asked if his palm guard was in place on 9/27/17, LPN #10 stated, "No. I probably should have circled my initials." When asked who was responsible for putting on splints, and palm protectors; LPN #10 stated that the CNAs put on the splints and the nurses have to ensure that the splints are in place. LPN #10 was asked to review Resident #12's Kardex with this surveyor. LPN #10 showed this writer Resident #12's Kardex. When asked how CNA's would know to put a palm protector to Resident #12's left hand if it is not documented on the Kardex, LPN #10 stated that CNA's would get that information in a verbal report. At this time LPN #10 accompanied this surveyor to Resident #12's room. LPN #10 confirmed that Resident #12's splint and palm protector were not in place.

On 9/28/17 at 11;33 a.m., an interview was conducted with CNA (certified nursing assistant) #4, Resident #12's CNA. When asked how CNAs would know what to put into place for skin preventive measures etc., CNA #4 stated that she would get report from the nurses or other CNAs. When asked if she had a reference to use that documented resident needs, CNA #4 stated, "If there is, I don't know where it is."

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services were made aware of the above concerns.

The facility policy titled, "Plans of Care" documents in part the following, "Direct staff

F 282

2.A quality review of current residents with Physician orders for hand splints/palms protectors has been performed. A quality review of current residents with orders for Antipsychotic medications has been performed. A quality review of residents with orders for blood pressure and blood glucose monitoring has been performed. A quality review of residents with orders for HIV medications has been performed. A quality review of residents with orders for prescribed

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938 0301

CLIVILI	COT ON MEDIONICE	G WILDION OLIVIOLO	Γ		C	MB NO.	0938-0391
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
		495362	B. WING	·			C 29/2017
NAME OF F	PROVIOER OR SUPPLIER			STRI	EET AOORESS, CITY, STATE, ZIP COOE	1 09/	29/2017
				1	THOMPSON STREET		
ASHLAN	D NURSING AND REI	HABILITATION			HLAND, VA 23005		
(X4) IO	SUMMARY STA	TEMENT OF OFFICIENCIES	10	<del></del>	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCEO TO THE APPROPOSE OFFICIENCY)	Ĥ R E	IX5) COMPLETION DATE
F <b>2</b> 82	Continued From pa	age 82	· F	282			
	•	nderstand and follow their	ι ,	-02			*
		Care. If unable to implement					
		, notify the Clinical Nurse or					
	Care Planning Coo				performed. Follow u	'n	
		upport his (sic) can be	<b>=</b>		based on findings.	۲	
	provided and plan	of care changed if necessary."			pasea on minings,		
	No further informat	ion was presented prior to exit.			3.Licensed Nurses re	i	
		•	-		educated by		
	h. The facility staff:	failed to follow the written plan	-				
		non-pharmacological			DCS/Designee regard	gnit	
		to the administration of Ativan	• •		following Physician		
		multiple occasions in July.	٠.		orders regarding wo	und	
	Davidson of The side of	4 #4 Ole clinical report versaled			care implementation		
		t #12's clinical record revealed ander hospice services on			and treatment. Licer		
		owing order was written:					·
		grams)/ML (milliliter) give 0.25			Nurses re-educated		
		rs prn (as needed) anxiety."			DCS/Designee regar	ding	
					following Physician		
		t #12's "Psychoactive			orders on document	ina	
		are plan dated 9/08/16,	-		on Treatment	.iiig	
		llowing intervention: drug interventions." This					**, * * •
	intervention was ini		- '		Administration Reco	rd	٠.
	IIICI VCITIOII WAS IIII	-		-	(TAR). DCS/Designee	3	
	Review of Resident	t #12's July 2017 MAR		"	during Morning Clin	ical	•
		stration record) revealed that	•			Cal	
•	Resident #12 recei	ved Ativan 0.25 mg on 7/5/17,			Meeting to conduct		
		7. There was no evidence in			quality monitoring o		
		hat non-pharmacological attempted prior to the			skin assessments an	d	}
	administration of At	·			TARs daily 4 weeks,		
					weekly x4 and then		
		ne MAR dated 7/2017,			monthly, PRN and a	_	
		llowing under "Nurse's			* ***		
		'Date: 7/5. Drug/Strength Reason: aggitated (sic)."			indicated.		

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CENTE	FORM APPROVED				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETED
NAME OF	DROVIDER OR SUPPLIED	495362	B. WING		C 09/29/2017
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF OEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEOED BY FULL TAG REGULATORY OR LSC IOENTIFYING INFORMATION)		ID PREF TAG		TION (X5)	
F 282	on 7/15/17 and 7/2 July 2017 MAR or	uired Ativan to be administered 8/17 could not be found on the in the July 2017 nursing notes.	F:	DEFICIENCY)	
	conducted with LPI #10, Resident #12' about the process a prn (as needed) a #10 stated that she and their behaviors redirection and dist medication. LPN # non-pharmacologic she would administ medication. When attempt non-pharmacologic documented, LPN in non-pharmacologic documented on a b When asked how s	cal interventions are ineffective, ter the prn anti-anxiety asked if she would always-acological interventions, LPN would. When asked if - act all interventions attempted are		4.DCS/Designee to conduct quality monitoring regardin physician notificatio with documentation the medical record a indicated. Findings t communicated to the QAPI committee monthly and as indicated. Quality monitoring schedule	n in es o be e

A July 2017 behavior sheet for Resident #12 could not be found in the clinical record.

prior to administering Ativan if it is not

Ativan, LPN #10 stated that if

documented, LPN #10 stated, "You wouldn't."

When asked if Resident #12's care plan was

followed if non-pharmacological interventions were not attempted prior to administering prn

non-pharmacological (interventions) were not attempted then the care plan was not followed.

On 9/29/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director, and ASM #2, the DON (Director of

monitoring schedules modified based on findings 5.November 14, 2017

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	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ		CONSTRUCTION	(X3) OA	TE SURVEY MPLETEO
		495362	B. WING			09	C 9/29/2017
NAME OF	PROVIOER OR SUPPLIER			ŞT	REET AOORESS, CITY, STATE, ZIP COOE		// ZJ/ZO []
ASHLAN	ND NURSING AND RE	HABILITATION			6 THOMPSON STREET		
	SUMMARY RT	TEL (ENIT OF OFFICIENCIES			SHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR OEFICIENCY)	II O B E	IX5I COMPLETION OATE
F 282	Continued From pa	age 84	F2	282	_		
	=	rvices, were made aware of	-				,
	No further informat	tion was presented prior to exit.					-
	information was ob Institutes of Health.	m.nih.gov/pubmedhealth/PMH		-			•
	#15's written plan o	aff failed to follow Resident of care for obtaining blood red by the physician and per e plan of care.					
	10/3/16 with diagnoral limited to: seizures, disease, diabetes, stroke. The most reassessment, with a resident as having BIMS (brief interviethe resident was codecisions. The resident	admitted to the facility on oses that included but were not , schizophreriia, kidney high blood pressure and ecent MDS, a quarterly an ARD of 7/7/17 coded the scored a 13 out of 15 on the ew for mental status) indicating ognitively intact to make daily ident was coded as requiring aff for all activities of daily					
	plan initiated or 10. documented, "Focumented, "Focumented, "Focumented of the plant of the plan	t #15's comprehensive care 1/4/16 and revised on 10/19/16 us. The resident has potential fusion r/t (related to) HTN re), DiabetesInterventions. red and prn (as needed)."  sician's order dated 9/21/17 itor BP (blood pressure) 2 x					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILOING COMPLETEO C 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH OFFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULO BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE **OEFICIENCY)** F 282 Continued From page 85 F 282 Thursday." Review of Resident #15's MAR (medication administration record) documented, "Monitor blood pressure 2x a week (goal <140/90) Sunday + Thursday." 9/24/17 had a box around it indicating the blood pressure was to be obtained on that day. There was no blood pressure or nurse's initials in the box. Review of the nurse's notes for 9/24/17 did not evidence documentation of the resident's blood pressure. An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked why the residents had care plans, LPN #3 stated, "To make sure we're following protocol and things the patient needs from the beginning to the end." When asked why staff followed the care plan, LPN #3stated, "Because it's what's best for the resident." When asked to review Resident #15's MAR for the 9/24/17 blood pressure, LPN #3 stated, "I can't speak to that." When asked if the blood pressure would be documented anywhere else. LPN #3 stated, "No, it's only on the MAR." When asked what the empty box on 9/24/17 meant. LPN #3 stated, "It wasn't done." On 9/28/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator/executive director.

and ASM #2, the director of nursing/clinical services, were made aware of the findings.

Review of the facility's policy titled, "Plans of Care" documented, "Direct care staff should be aware, understand and follow their Resident's

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		A MEDICAID SERVICES	<del></del>		(	<u> MB NC</u>	D. <b>0</b> 938- <b>0</b> 391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495362	B. WING				C
NAME DF	PROVIDER OR SUPPLIER		·	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0	9/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906 T	THOMPSON STREET LAND, VA 23005		
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F 282	Continued From pa	age 86	F2	282			
	No further informat	ion was provided prior to exit.					
	written plan of care blood glucose befo	failed to follow Resident #15's to monitor the resident's re meals and at bedtime per er and comprehensive care					
	revised on 10/19/1 Resident is at Risk	plan initiated on 10/4/16 and 6 documented, "Focus. The for Metabolic Complications r/tesInterventions. Blood pordered."	:				
	2017 documented,	ician's orders for September "CHECK BLOOD SUGAR AND AT BEDTIME FOR DM					
	MEALS AND AT BE Further review of the	ember 2017 MAR ECK BLOOD SUGAR BEFORE EDTIME FOR DM. 05/30/17." he MAR revealed that the blood cked on 11 occasions out of 72		-	<b></b>		
	p.m. with LPN (lice resident's nurse. Whad care plans, LP we're following proneeds from the begasked why staff foll stated, "Because it When asked to rev	onducted on 9/28/17 at 12:15 nsed practical nurse) #3, the /hen asked why the residents N #3 stated, "To make sure tocol and things the patient ginning to the end." When lowed the care plan, LPN #3 's what's best for the resident." iew Resident #15's MAR for ted blood sugars 1 PN #3					

stated, "I can't speak to these." When asked if the

		AND HUMAN SERVICES				PRIN	NIEU: 10/12/2017
		& MEDICAID SERVICES	т —			OME	ORM APPROVED 3 NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		3) DATE SURVEY COMPLETED
		495362	B. WING				C 00/20/2017
NAME OF	PROVIDER OR SUPPLIER		<del>'</del>	ST	REET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	09/29/2017
ASHLAN	ND NURSING AND REI	HARII ITATION			6 THOMPSON STREET	-	
710112	- TORONO AL	TABLETATION	1		SHLAND, VA 23005		
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F 282	Continued From pa	ane 87	E 4	200			
• ==		d be documented anywhere	ГΖ	282			
		i's chart, LPN #3 stated, No.					
	It's on the MAR." W	Vhen asked what the blank					
		N #3 stated, "It wasn't done."					
		t was important to obtain the gar, LPN #3 stated, "To make					
		ot having a hypoglycemic (low					
	blood sugar) episod	de. Especially so we know if					
	we should hold it (th	he insulin)."					
	at 3:30 p.m. with LF When asked what t	ew was conducted on 9/28/17 PN #13, the resident's nurse. the blank space on the MAR ated, "It usually means it					
		p.m. ASM (administrative staff SM #2 were made aware of					
	No further informati	ion was provided prior to exit.					-
	written plan of care	failed to follow Resident #23's to obtain blood glucose levels per the physician's orders and re plan.	· ·		-		
	5/18/15 with diagno limited to: diabetes, and shortness of brecent MDS, a quar ARD of 7/12/17 cod scored a 12 out of 1 mental status indicates.	admitted to the facility on oses that included but were not high blood pressure, anemia reath. Review of the most rerly assessment, with an ded the resident as having 15 on the brief interview for ating the resident was make daily decisions. The					

resident was coded as requiring set up assistance from staff except for dressing and

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0939, 0304

<u>CENTER</u>	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES				0'	710 VIC	M APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		PLE CONSTRUCTION		(X3) DA	). 0938-0391 TESURVEY MPLETED
		495362	B. WING				00	C )/20/2047
NAME OF I	PRDVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZI	ים כטטב	l us	/29/2017
			[		906 THOMPSON STREET	IF LUDE		
ASHLAN	ND NURSING AND REP	HABILITATION			ASHLAND, VA 23005			
240.10	STIMMARY STA	TELECTE OF DECIDIENDIES						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CRDSS-REFERENCED TO T DEFICIENC	TON SHOULD THE APPROPI	DE	IX5) COMPLETION DATE
F 282	Continued From pa	age 88	F 2	282	>			
		e resident was coded as	1	<u> </u>	<u>-</u>			
		tance of one staff member.						
	Ledniind me assisi	ance of one start member.						
	Review of Residen'	t #23's comprehensive care						
		15/17 and revised on 3/8/17						
		us. The Resident is at Risk for						
	Metabolic Complica							
		d Glucose levels as ordered."						•
	***************************************	• • • • • • • • • • • • • • • • • • •						
		ember 2017 physician's orders						
		CK BLOOD SUGAR BEFORE						
		ne order date was 2/26/27.						
[								
	Review of the Septe							
	documented, "CHE	CK BLOOD SUGAR BEFORE						
		irther review of the MAR						•
		esident did not have a blood						
		mpleted before meals as						•
ĺ	ordered on eight oc	casions out of 82						
	opportunities.							•
		onducted on 9/28/17 at 12:15						-
		nsed practical nurse) #3, the						
		hen asked why the residents						
		N #3 stated, "To make sure						
		ocol and things the patient						
		ginning to the end." When						
ĺ		owed the care plan, LPN #3						
ł		s what's best for the resident."						
ļ		iew Resident #23's MAR for						
		PN #3 stated, "I can't speak to dif the blood sugars would be					-	-
		on the bibbo sugars would be lere else in the resident's						
ı		d, No. It's on the MAR." When						
t	•	nk spaces meant, LPN #3						
ı		ine." When asked why it was						
		the resident's blood sugar.						
		make sure that they're not						
ı		mic (low blood sugar) episode.						J
		/						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CDDE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL [X5] PRÉFIX PREFIX (EACH CDRRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY DR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282 Continued From page 89 F 282 Especially so we know if we should hold it (the insulin)." A telephone interview was conducted on 9/28/17 at 3:30 p.m. with LPN #13, the resident's nurse. When asked what the blank space on the MAR meant, LPN #13 stated, "It usually means it wasn't done." On 9/28/17 at 5:00 p.m. ASM #1 and ASM #2 were made aware of the findings. No further information was provided prior to exit. The facility staff failed to follow Resident #2's comprehensive care plan to provide the HIV (human immunodeficiency virus (2)) medication Triumeg (1) to Resident #2 and failed to follow the 6/23/17 infectious disease doctor's order to continue the Triumeq. Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV, dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a guarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded the resident as having both short and long term memory problems and as severely impaired cognitively. Resident #2 was coded as rarely or never being able to understand others or to be understood. The resident was

as having HIV.

coded as requiring assistance from staff for all activities of daily living. The resident was coded

Review of Resident #2's care plan initiated on 5/12/17 documented, "Focus. The resident has

PRINTED: 10/12/2017 FORM APPROVED OMB NO 1038 1301

	05 055050505	I			<u>C</u>	<u>MB NO. (</u>	)9 <u>3</u> 8-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE S COMPL	SURVEY -ETED
		495362	B. WING	·		09/20	9/2017
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		90	REET ADDRESS, CITY, STATE, ZIP CODE 6 THOMPSON STREET SHLAND, VA 23005	1 03/23	572017
(X4) ID PREFIX TAG	(EACH OEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) DE	(X5) COMPLETION OATE
F 282		nge 90 Ited to) medical dx (diagnosis) Is. Provide medications as	F	282			
	note documented in 65-year-old African probable HIV association, she is eating weight, medication confirmed. Prescrip (medications) by High abacavir/dolutegrav [history]): PO (by m 2. continue Triumed	17 infectious disease doctor's part, "In brief, this is a American woman with HIV - ciated dementia Per the givery little and is losing adherence has been etions & Documented Meds (history): vir/lamivudine (Triumeq) (Hx outh) dailyAssessment/Plan: q." A handwritten note sferred to telephone order					
		ent's 6/23/17 telephone orders cumentation regarding the	-				
	administration record documentation rega	2017 MAR (medication rd) did not evidence arding the Triumeq.				7	•
	Review of the July a not evidence docum Triumeq.  An interview was cop.m. with the reside about the resident's that sometime in 20 gone to an HIV clinidiagnosed with HIV	and August 2017 MARs did nentation regarding the enducted on 9/27/17 at 3:05 nt's daughter. When asked history, the daughter stated 14 or 2015 her mother had c in New York. She was and was started on				- -	
· – -	sister brought the m	auginter stated she and her nother to Virginia to get her that the New York facility had					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINT	ED: 10/12/2017
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FO	RM APPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3)	NO. 0938-0391 OATE SURVEY COMPLETEO
		495362	B. WING	3			С
NAME OF I	PROVIOER OR SUPPLIER		1	$T^{-}$	STREET AOORESS, CITY, STATE, ZIP CODE	ــــــــــــــــــــــــــــــــــــــ	09/29/2017
ASHLAN	D NURSING AND RE	HAB)LITAT)ON			906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	LOBE	(X5) COMPLETION DATE
F 282	Continued From pa	ne 91	<b>c</b> ·	282			<del></del>
		of her HIV medications for	г.	202	2		.
		er stated that she told the					ĺ
	facility that the resid	lent was on the HIV				-	· · · · · · -
		she needed her medications.					
		d she had brought the q) to the facility and that the					
		en given to her mother.					
		· · · · · · · · · · · · · · · · · · ·					
		onducted on 9/28/17-at-12:15-				**	
		nsed practical nurse) #3.				-	
		e residents had care plans, make sure we're following					
		the patient needs from the					
							First Constant
		an, LPN #3 stated, "Because					
		ne resident." When asked to					
		s MAR for documentation of meq, LPN #3 stated, "I can't					
			:				
	administration woul	d be documented anywhere		-			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
		s chart, LPN #3 stated, No.					
		hen asked what the blank #3 stated, "It wasn't done."					
	spaces meant, LFN	#3 stated, it wasn't done.					**1 -
	On 9/28/17 at 5:00	o.m. ASM #1, the	4.				Gerri L
		tive director, and ASM #2, the					-
		linical services, were made				•	* . = v.
	aware of the finding	<b>5.</b>					
	No further information	on was provided prior to exit.					~
	Complaint deficience	· ·					
•	- Complaint deliciterie	J	•				-
		abacavir, an HIV medicine.					
		acavir-containing products,					
, ··· _=		nay have a serious allergic itivity reaction) that can cause					

death. This information was obtained from: https://aidsinfo.nih.gov/drugs/534/triumeq/0/patie

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL 1X51 PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 92 F 282 nt 2. HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection. The abbreviation "HIV" can refer to the virus or to HIV infection. HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection. HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the ... United States, HIV is spread mainly by having anal or vaginal sex or sharing drug injection equipment with a person who has HIV. Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV regimen) every day. ART can't cure HIV infection, but it can help people with HIV live longer, healthier lives, HIV medicines can also reduce the risk of transmission of HIV. This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/fac t-sheets/19/45/hiv-aids--the-basics 5. The facility staff failed to follow Resident #6's comprehensive care plan in regards to medications. Resident # 6 was admitted to the facility on

Resident # 6 was admitted to the facility on 7/14/11 and was most recently readmitted on 9/7/17 with diagnoses that included but were not limited to: cancer, anemia, coronary artery disease, gastroesophageal reflux disease, diabetes, seizure disorder, cerebral palsy (1), congestive heart failure. stroke, depression, and end stage renal disease.

Resident #6's most recent MDS (minimum data

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	: 10/12/2017 1APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OI	(X3) DA1	. 0938-0391 TE SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STAT	E, ZIP CODE	09	/29/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	PC	(X5) COMPLETION DATE
F 282	Continued From pa	ge 93	F2	282				<del> </del>
	set) assessment, as ARD (assessment r coded Resident # 6 as able to understal coded as being cog	n Annual Assessment, with an reference date) of 8/5/17 as understood by others and nd others. Resident # 6 was initively impaired making daily 4 out of 15 on the BIMS (brief		-				 
		#6's comprehensive care ollowing documentation:						
	Major Depressive d	edication for DX (diagnosis) of isorder date initiated: 8/9/16" - s*Medication as ordered	-					- - -
	Complications r/t (re Other disease procedisease) with hemo-	ood Glucose levels as 🗓	-	-				
	output and potential HTN (high blood pre Disease initiated 8	ent has decreased cardiac for alteration in perfusion r/t- essure) * Diabetes*Renal 8/9/16 and revised 8/17/16" s *Medications as ordered.				٠.		
	Review of Resident revealed the following	#6's physician orders				-		
	TABLET TAKE 1 TA	(APRO (2) 20MG (milligram) BLET BY MOUTH EVERY as signed by the physician on			••			

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				<u>OMB MO</u>	<u>. 0938-0</u> 391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE	TIPLE CONSTRUCTION DING		E SURVEY IPLETED
	495362	B, WING		1	C /29/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2017
ASHLAND NURSING AND RE	HABILITATION		906 THOMPSON STREET		
			ASHLAND, VA 23005		
(Y4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES	10			
PREFIX (EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREF TAG	CROSS-REFERENCED TO THE APPRI	LO BE	(X5) COMPLETION DATE
			DEFICIENCY)		
F 282 Continued From pa	age 94	F ·	282		į
1	BLOOD SUGAR EVERY DAY	•			
	0 4:30 PM." This order was				
signed by the physi	ician on 7/1/17 and 8/2/17.				
Dated 7/30/16: "DI	OVAN (3)160 MG TABLET				
TAKE 1 TABLET B	Y MOUTH DAILY." This order				
	physician on 7/1/17 and 8/2/17.				
, as signed 2, and	prijana and principal disa 6,2,17,				
Dated 1/24/17: "RE	NA-VITE (4) 0.8MG TABLET				
	Y MOUTH EVERY DAY." This				
,	y the physician on 7/1/17 and				
8/2/17.					
	•				
Dated 7/30/16: "NC	DRVASC (5) 10 MG TAKE 1-				
	H DAILY." This order was				
	ician on 7/1/17 and 8/2/17.				
aignod by the priyer	iolan ov. IIII i ana orași ii.				
Dated 5/15/17: "RE	NENLA (6) 800MG TABLETS				
	400 MG) BY MOUTH THREE	-			
	is order was signed by the				
physician on 7/1/17	and 8/2/17.	•			-
	.,				
	(medication administration				
record) for July and	August 2017 revealed the				•
following:			•		
			•		•
For July:			-		
	given at 9:00 a.m. one time				: -
out of 31 opportuni					
					-
	ood sugar at 6:30 a.m. was not	-			
	of 31 opportunities.		•		
	ood sugar at 4:30 p.m. was not				:
done one time out		-			_
- Rena-Vite was no	ot given at 9:00 a.m. one time				
out of 31 opportunit	ties.				
1					
For August:					
	given at 9:00 a.m. five times				

out of 31 opportunities.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOING \_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF OFFICIENCIES PROVIOER'S PLAN OF CORRECTION PRÉFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL (EACH CORRECTIVE ACTION SHOULO BE **PREFIX** COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 282 Continued From page 95 F 282 - Renvela not given at 7:30 a.m. four times out of 10 opportunities. - Renvela not given at 11:30 a.m. five times out of 10 opportunities. - Renvela not given at 4:30 a.m. two times out of 10 opportunities. - Norvasc was not given at 9:00 a.m. four times out of 31 opportunities. - Diovan not given at 9:00 a.m. four times out of 31 opportunities. During an interview on 9/28/17 at 1:55 p.m. with LPN (licensed practical nurse) # 5, LPN # 5 was asked the purpose of the care plan. LPN #5 stated that it was her understanding that the care plan was where staff would go to get information on how to care for the resident to include diet. medications, and therapy. The care plan is used by all nurses. The CNAs (certified nurse's assistants) use the Kardex for information to care for the residents. During an interview on 9/28/17 at 4:50 p.m. with ASM (administrative staff member) # 1, the administrator/executive director, and ASM # 2. the director of nurses/clinical services, this concern was shared. No further information was provided prior to exit. References: (1) Cerebral palsy refers to a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination Cerebral

palsy (CP) is caused by damage to or

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOING COMPLETEO С 495362 B. WING 09/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

#### ASHLAND NURSING AND REHABILITATION

ASHLAND, VA 23005

906 THOMPSON STREET

(X4) IO PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)

COMPLETION OATE

### F 282 Continued From page 96

abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance. The term cerebralrefers to the brain; palsy refers to the loss or impairment of motor function. This information was obtained from the website: https://www.ninds.nih.gov/Disorders/Patient-Care giver-Education/Hope-Through-Research/Cerebr al-Palsy-Hope-Through-Research#3104 2

(2) LEXAPRO - Escitalopram is used to treat depression and generalized anxiety disorder (GAD). It is an antidepressant that belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). These medicines work by increasing the activity of the chemical serotonin in the brain.

This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010165/?report=details

(3) DIOVAN - Valsartan and hydrochlorothiazide combination is used alone or with other medicines to treat high blood pressure (hypertension). This information was obtained from the website:

https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0012601/?report=details

(4) RENA-VITE -- Supplies your body with vitamin B and vitamin C. You might need extra vitamins because of an illness or other medicines that you are using. This information was obtained from the

https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0012655/

(5) NORVASC -- Amlodipine is used alone or together with other medicines to treat angina

F 282

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-A. BUILOING \_ COMPLETEO С 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID Ю PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD SE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLÉTION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG OEFICIENCY) F 282 Continued From page 97 F 282 (chest pain) and high blood pressure (hypertension). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0008948/?report=details (6) RENENLA -- Lowers the amount of phosphorus in blood of patients receiving kidney dialysis. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0012110/?report=details 6. The facility staff failed to follow Resident # 7's care plan in regards to medications. Resident # 7 was admitted to the facility on 3/28/13 and most recently on 3/10/17 with diagnoses that included but were not limited to: diabetes, dementia, hypertension, bipolar disorder, chronic obstructive pulmonary disease, atrial fibrillation, glaucoma, and irritable bowel syndrome. Resident # 7's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 8/5/17 coded Resident #7 as understood by others and as able to understand others. Resident #7 was coded as being cognitively intact for making daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status).

Review of Resident #7's comprehensive care plan revealed the following documentation:

"Focus: \*Potential fluid imbalance r/t (related to)

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		& MEDICAID SERVICES	<del></del>			O	MB NO.	. 0938-0391
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F 282		ects. Date Initiated: 3/16/17." as * Administer medications as	F2	282		-		
	"Focus: *The Resid	lent is at Risk for Metabolic iabetes. Date Initiated: 3/27/17 htions: *Blood Glucose levels						
	Review of physician documentation:	n orders revealed the following						_
	TABLET BY MOUT	SIX (1) 40 MG TAKE 1 H EVERY DAY" This order physician on 7/1/17 and 8/2/17.						
	100/ML (milliliter) IN SUBCUTANEOUSI THREE TIMES DAI 152-200 = 2 UNITS 251-300=6 UNITS, 351-400=10 UNITS GREATER THAN 4 BLOOD SUGAR IN SLIDING SCALE C BLOOD SUGAR IN	, 401-450=12 UNITS, 50=14 UNITS AND REPEAT 2 HOURS AND FOLLOW OVERAGE, IF REPEAT 2 HOURS AND STILL OVER						
	[medical doctor]" The physician on 7/1/17	•						-
		#7's MAR (medication rd) for July and August 2017, ng:						-
B (2 <u>012</u>		ilin blood sugar not checked times out of 31 opportunities.						

- Sliding Scale Insulin blood sugar not checked

		AND HUMAN SERVICES				PRINT	ED: 10/12/2017
	***	& MEDICAID SERVICES	<del></del>			OMB 4	RM APPROVED NO. 0938-0391
	OF OEFICIENCIES F CORRECTION	(X1] PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	[X3] [	DATE SURVEY COMPLETED
		495362	B. WING	' <del></del>			C
NAME OF F	PROVIDER OR SUPPLIER		<del></del>	STRE	ET ADORESS, CITY, STATE, ZIP COD		09/29/2017
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F 282	Continued From pa	ge 99	E 4	202			
		e out of 31 opportunities.	F .	282			}
		or and a opposite mass.	•				
	opportunities Sliding Scale Insu	en one time out of 31	-				-
	<ul> <li>Sliding Scale Insu</li> </ul>	me out of 31 opportunities. lin blood sugar not covered a.m. one time out of 9					-
	- Sliding Scale Insu at 4:30 p.m. two tim	lin blood sugar not checked es out of 31 opportunities. lin blood sugar not covered					e man
		o.m. five times out of 12					
	LPN (licensed pract asked what the purp 5 stated that it was I care plan was where information on how include diet, medica plan is used by all not be a sked by a sked by a sked by a sked by a sked by a sked by a sked by	on 9/28/17 at 1:55 p.m. with ical nurse) # 5, LPN # 5 was cose of the care plan. LPN # ner understanding that the estaff would go to get to care for the resident to tions, and therapy. The care urses. The CNAs (certified use the Kardex for information ents.		- -			
	ASM (administrative administrator/execut	on 9/28/17 at 4:50 p.m. with staff member) # 1, the live director, and ASM # 2, s/clinical services, this					
	"ProcedureDirect	policy: "Plans of Care" under care staff should be aware, w their Resident's Plan of					
		n was provided prior to exit.					

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	/Y2) MUI		CONSTRUCTION	0	MR MO	<u>0938-0391</u>
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			0			<del></del>		
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NAME OF	PROVIOER OR SUPPLIER		•	STR	REET ADORESS, CIT	TY, STATE, ZIP COOE	09/2	29/2017
ASHLAN	ID NURSING AND REI	HARII ITATION			THOMPSON STR			
V 101.25 1.		TABLETATION		ASI	HLAND, VA 230	005		
(X4) iO		TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL	io		PROVIDER	S PLAN OF CORRECTION		ive
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORF	ECTIVE ACTION SHOULD ENCEO TO THE APPROP	RF	(X5) COMPLETION
					200	OEFICIENCY)	KIALE	DATE
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F 282	Continued From pa	ge <b>1</b> 00	F 2	282				
	Deference							
	References:							
	(1) LASIX - furosem	nide tablet Furosemide				ž.	1 -	
<u> </u>	belongs to a group	of medicines called loop						
		vn as water pills). Furosemide -			<b></b>		•	
	is given to neip trea	t fluid retention (edema) and sed by congestive heart =			F3			· -
		e, kidney disease, or other			1.	Resident#2 is		
	medical conditions.	This information was				currently receivin	g	
	obtained from the w					prescribed HIV	_	
	nπps://www.ncbi.nin T0010414/?report=	n.nih.gov/pubmedhealth/PMH				medications as pe	or.	•
	10010+1-Wilepoll-I	ucians ·				Physician order.	-1	
		lin lispro injection, USP (rDNA				Resident#15's blo	_ 1	radio
		is a fast-acting type of					oa	
- ,		e of many hormones that the ve eat into energy. This				glucose is being		
		ained from the website:	-			obtained and		
		n.nih.gov/pubmedhealth/PMH				documented in th	e	
F 200	T0010736/ helps					medical record as		-
	FOR HIGHEST WE	PROVIDE CARE/SERVICES	F 3	09		per Physicians		
00 2				-		order. Resident#2	3	
	483.24 Quality of life					blood glucose is		-
		ndamental principle that not services provided to facility				being obtained ar	nd	****
		ident must receive and the				documented in th		
		the necessary care and			٠		-	<u>.</u>
		maintain the highest				medical record as		
	well-being, consister	mental, and psychosocial				per Physician ord	er.	İ
	comprehensive asse	essment and plan of care.				Resident#17 is		37
		•				receiving prescrib	ed	-
	483.25 Quality of car					pain medication a	s	ļ
··		undamental principle that ent and care provided to-				per Physician's		.
		sed on the comprehensive				order.		}
	-	1						I .

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	OF OFFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	<u>_</u>	WID NO. US	
ANO PLAN (	OF CORRECTION	IOENTIFICATION NUMBER:	1	ING	<del></del>	(X3) OATE \$U COMPLE	
		495362	B. WING			C 09/29/	2017
NAME OF	PROVIOER OR SUPPLIER			STREET AOORESS	S, CITY, STATE, ZIP COOE	03/23/	2017
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F 309	assessment of a re that residents rece accordance with p practice, the comp care plan, and the	esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices, including	F	909			
	but not limited to th	ne following:			Resident#32's pain		•
	provided to resider consistent with prothe comprehensive and the residents'  (I) Dialysis. The faresidents who requestrices, consister of practice, the concare plan, and the preferences. This REQUIREME by:  Based on resident family interview, facility staff failed to and services and trhighest level of phyresidents in the sur #15, #23, #17, #32  1. The facility staff disease physician's	ent. Insure that pain management is into who require such services, fessional standards of practice, is person-centered care plan, goals and preferences.  It with professional standards in the professional standards in prehensive person-centered residents' goals and  In it is not met as evidenced interview, staff interview, cility document review and it was determined that the provide the necessary care reatment to maintain the resical well-being for ten of 34 vey sample, Residents #2, #6, #7, #16, #12 and #10.  If alled to follow the infectious of 6/23/17 order to continue armed (1) resulting in a delay of			and anxiety medication is being administered as per Physician order. Resident#6's prescribed medications and treatments are being administered as per Physician order. Resident#7 prescribed medications and treatments as per peing administered as per MD order. Resident#16's order for notification to the Physician for		
	immunodeficiency v	sident's HIV (human virus (2)) infection. The ed HIV medication on 9/13/17.					- -
	2 a The facility sta	ff failed to obtain Resident			•		į

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) OATE SURVEY IOENTIFICATION NUMBER: A. BUILOING \_\_\_\_\_ COMPLETEO С 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF OFFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION Ю (EACH OFFICIENCY MUST BE PRECEOED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG OEFICIENCY) F 309 Continued From page 102 F 309 #15's blood pressure twice a week, as ordered by the physician on 9/21/17. 2. b. The facility staff failed to check Resident #15's blood sugar before meals and at bedtime, per the 6/13/17 and 7/27/17 physician's orders. saturation levels The facility staff failed to follow Resident #23's below 90% has been physician's order date 2/26/17, to check Resident discontinued by the #15's blood glucose before meals. Physician. Resident 4. The facility staff failed to administer Resident #12 has left hand #17's pain medication per physician's order on palm protector multiple dates in September 2017. applied as ordered 5. The facility staff failed to administer Resident and application is #32's pain and anxiety medications per physician's order on 7/30/17. documented. The facility has added 6. The facility staff failed to administer medications and treatments to Resident # 6 as nonordered by the physician. pharmacological intervention has 7. The facility staff failed to administer medications and treatments to Resident # 7 as been added to ordered by the physician. Resident#12's 8. The facility staff failed to obtain oxygen profile. The saturation levels in order to notify the physician if Physician has levels dropped below 90 % for Resident #16. discontinued the 9. a. The facility staff failed to follow physician's

orders and apply a left hand palm protector and a

non-pharmacological-pain interventions prior to

the administration of Morphine [1] to Resident #12; failed to assess pain location and intensity

right hand splint to Resident #12's hands.

9b. The facility staff failed to attempt

order to elevate

legs with two

Resident#16 lower

pillows while in bed

and seated in chair.

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONS	TRUCTION	(X3) O/	ATE SURVEY OMPLETED
		495362	B. WING				С
NAME OF I	PROVIDER OR SUPPLIER		13111110		A000500 017V 07-7-	0	9/ <b>29</b> /2017
					AOORESS, CITY, STATE, ZIP COOE MPSON STREET		
ASHLAN	ID NURSING AND RE	HABILITATION			ND, VA 23005		
(X4) IO	SUMMARY STA	TEMENT OF OEFICIENCIES		ASITEM			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCEO TO THE APPROP OEFICIENCY)	RE	COMPLETION OATE
F 309	Continued From pa	nge 103	E 6	100			<del></del>
			F3	109	•		
	prior to the administration of Morphine and failed to document the effectiveness of Morphine after it						
		was administered to the resident.			Resident#2	-	
	40 Tr 6 "" + 5		-		currently resides in		
	10. The facility staff failed to follow a physician order to keep Resident #10's bilateral lower legs elevated on two pillows when in bed and seated in a chair.				the facility and has		• .
					·		
					no s/s of adverse	_	
					effects. Resident#1		
	The findings include:				currently resides ir	ı	,-
	The findings include:				the facility and has	;	
		ailed to follow the infectious-			no s/s adverse		• • •
	disease physician's 6/23/17 order to continue Resident #2 on Triumeq (1) resulting in a delay of treatment of the resident's HIV (human				effects. Resident#2	23	en en en en en en en en en en en en en e
					currently resides in		-
		virus (2)) infection. The	-		the facility and ha		
	resident was ordered HIV medication on 9/13/17.				·	3	- 
	D1-1				no s/s adverse		
		Imitted to the facility on 5/1/17 included but were not limited			effects. Resident#		
	9	depression, difficulty -			currently resides i	n	124 8 11
	swallowing and elev	ated cholesterol. The most			the facility and ha	S	-
		um data set); a quarterly			no s/s adverse		<b>⇒</b> .
		n ARD (assessment reference ed the resident as having both	£ +		effects. Resident	32	
	•	memory problems and as			currently resides		
	severely impaired c	ognitively.Resident #2 was					4
		ever being able to understand			the facility has no	J	<b>-</b> *.
	others or to be understood. The resident was		-		s/s of adverse		
		coded as requiring assistance from staff for all activities of daily living. The resident was coded			effects. Resident	#32	
	as having HIV.		_				
		700	•* -				
		#2's care plan initiated on d, "Focus. The resident has					
		ted to) medical dx (diagnosis)			_		
		Provide medications as	-		-		

ordered."

## DEPARTMENT OF HEALTH AND HUMA

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		AND HOMAN SERVICES			FORM ADDROVE	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039	
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) OATE SURVEY COMPLETEO	
 		495362	B. WING		Ç	
NAME OF PROVIOER OR SUPPLIER			B. WING.		09/29/2017	
				STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET		
ASHLAND NURSING AND REHABILITATION				ASHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATIONI	IO PREFI) TAG	PROVIOER'S PLAN OF CORREC	LILO RE COMPLETION	
F 309	Continued From pa	ge 104	F 3	09		
	Review of the nurse's note dated 5/2/17 at 2:00 p.m. documented, "Currently awaiting meds (medications) to arrive, resident is on a medication called Truimeq 600 (mg)-50 (mg)-300 mg the medication was called in by pharmacy to be @ (at) the cost of \$2827 and insurance would not cover medication and the facility would have to fort (sic) the bill, pharmacy advise (sic) not to fill prescription until (nurse) (writer) speak to family and MD (medical doctor) to see if their (sic) an equivenlant (sic) med (medication) that can be order (sic) the insurance will cover. MD (name of physician) notifies (sic) of situation and asked to prescribed (sic) something else, MD instructed to call pharmacy (sic) ask for equivenalt (sic), pharmotish (sic) stated theirs (sic) is not a medication that is Generic for medication and that some-thing totally different would have to be ordered. MD (name of physician) notified once more and made aware of pharmacy answer to question, MD decided to D/C particular medication and refer resident to infectious control center ASAP (as soon as possible), order has been given to unit clerk to set up. Awaiting appoint (appointment) Resident RP (responsible party) daughter has been called and made aware of d/cing (discontinuing) of medication."  Review of the physician's history and physical dated 5/2/17 documented, "History of Present Illness: The patient is a 65-year-old female with history of dementia, HIV, who is admitted here for rehabilitation. She came with orders for			is currently resided in the facility and has no s/s of adverse effects. Resident#6 currently resides the facility and has no s/s of adverse effects. Resident currently resides the facility and has no s/s of adverse effects. Resident currently resides the facility and has no s/s adverse effects. Resident currently resides the facility and has no s/s adverse effects. Resident currently resides the facility and has a s/s adverse the fa	in as #7 in as #12 in as #16 in	

antiretroviral, Triumeq, for HIV from the other

it [medication]. I was asked to review and

facility with no records regarding HIV, who has ordered it, what are the CD4 (HIV) counts (4). Here [at the facility], the insurance is not covering no s/s adverse

effects.

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		& MEDICAID SERVICES			O	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED
		495362	B. WING	i		С
NAME OF PROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE	09/29/2017
					THOMPSON STREET	
ASHLAND NURSING AND REHABILITATION					HLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE COMPLETION
F 309	any history. We cal RP (responsible pa been started on this any HIV doctor before History of human in Recommendations. Triumeq and refer thospital) for further  Review of a physici documented, "Start (supplied by daught mouth) daily. Dx (direceived*."  Review of the physici documented, "D/C (600-50-300 after 8-to f/u (follow up) with clinic)."  Review of Resident administration recond 600-50-300 Give 1 supply) Dx HIV." The documented as bein 5/22/17.  Review of the 6/23/note documented in 65-year-old African probable HIV associations.	ge 105 Int is demented. Cannot give led the patient's daughter or rty), and she said she has not seen one. Assessment and Plan: 1. Inmunodeficiency virus. In We will discontinue the o HIV Clinic at (name of recommendations."  an's order dated 5/13/17 Triumeq 600-50-300 tablet ter) Give 1 tablet po (by agnosis) HIV *8-day supply  cian order dated 5/28/17 (discontinue) Triumeq day supply given. Pt (patient) h (name of hospital HIV  #2's May 2017 medication rd documented, "Triumeq tablet by mouth daily (8-day e medication was ng given from 5/14/17 through  17 infectious disease doctor's part, "In brief, this is a American woman with HIV - iated dementia Per the very little and is losing	F	309	2.A quality review of current residents with Physician orders for hand splints/palms protectors has been performed. A quality review of current residents with orders for Antipsychotic medications has been performed. A quality review of residents with orders for oxygen saturation and blood glucose monitoring has been performed. A quality review of residents with orders for blood pressure monitoring has been performed. A quality	
	weight, medication adherence has been confirmed. Prescriptions & Documented Meds (medications) by Hx (history): abacavir/dolutegravir/lamivudine (Triumeq) (Hx):				review of residents with	

PO (by mouth) daily...Assessment/Plan: 2.

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FORM APPROVED
OMB NO. 0938-0301

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMBN	KM APPROV	ED.	
	OF OFFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU A. BUILO		CONSTRUCTION	(X3) C	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETEO		
		495362	B. WING	i		C			
NAME OF PROVIOER OR SUPPLIER				STRI	EET AOORESS, CITY, STATE, ZIP COOE		09/29/2017		
ASHLAND NURSING AND REHABILITATION				1	THOMPSON STREET HLAND, VA 23005				
(X4) IÓ PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	U O BE	(X5] COMPLETI OATE	ION	
F 309	Continued From page 106 continue Triumeq." A handwritten note documented, "Transferred to telephone order 6/23/17 8 pm."  Review of Resident #2's 6/23/17 telephone orders did not evidence documentation regarding the Triumeq.		F	309					
					s				
	Review of Resident #2's June 2017 MAR (medication administration record) did not evidence documentation regarding the Triumeq.  Review of the July and August 2017 MARs did not evidence documentation regarding the Triumeq.  Review of the infectious disease doctor's orders dated 9/1/17 documented, "Plan is to start Raltegravir (2) + Descovy (3) (if prior authorization required for Descovy, then use Truvadavoid further Rx [treatment] delays)."				orders for HIV medications has	orders for HIV medications has been			
					performed. A qu review of reside	performed. A quality review of residents with orders for prescribed			
					medications has performed. A qu review of treatm orders has beer	been ality ent		÷,	
	Review of the September 2017 MAR (medication administration record) documented, "Descovy 200-25mg (milligrams) 1 tab (tablet) PO (by mouth) Daily. Isentress 400 mg 1 tab PO BID (twice a day)." The start date was documented as being 9/13/17.				performed.	' <u>-</u>			
	p.m. with OSM (other director of social ser who assisted reside medications that the	insurance company did not ed. "The business office							
	An interview was co	nducted on 9/27/17 at 3:05							

p.m. with Resident #2's daughter. When asked

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		AND HUWAN SERVICES				FORM APPROVE
		& MEDICAID SERVICES	· · · · ·			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495362	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS C	CITY, STATE, ZIP CODE	09/29/2017
				906 THOMPSON ST		
ASHLAN	ID NURSING AND RE	HABILITATION	]	ASHLAND, VA 23		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	ER'S PLAN OF CORREC RRECTIVE ACTION SHO ERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION
F 309	Continued From pa	age 107	F 3			
_		s history, the daughter stated	1 3	09	<ol><li>Licens</li></ol>	ed Nurses re-
		014 or 2015 her mother had				ted by
		ic in New York. She was				•
	diagnoses with HIV	and was started on				esignee
		aughter stated she and her	<u>.=</u>		regard	ling following
		nother to Virginia to get her			Physic	ian orders on
		the New York facility had				ation of hand
	•	y of her HIV medications for ter stated she told the facility				
		ent #2) was on the HIV				and palm
		t she needed her medications.			protec	•
		d that she had brought the			follow	ing Physician
		eq) to the facility and the				regarding
	medication had bee	en given to her mother.			medica	• •
	A :					
		onducted on 9/28/17 at 8:10				istration and
		nsed practical nurse) #6, the nasked if staff followed the			docum	entation,
		ultant, LPN #6 stated, "When			followi	ng Physician
		ult back we order anything				on blood
		asked why Resident #2 wasn't				
		as ordered by the infectious				e monitoring
		6/23/17, LPN #6 stated, "She			and do	cumentation,
		asked to review the 6/23/17			followi	ng Physician
		doctor's orders, LPN #6 stated, ne (LPN #13) never showed				on blood
		vould have followed up. I				
	would have called (					e monitoring
	0 01001/2 / / /=					cumenting,
		p.m. an interview was		•	obtaini	ng oxygen
		M (other staff member) #6, the nager. OSM #6 was asked		-	saturati	ion and
		staff follows if insurance does	-		docume	enting, and
	•	t's medication. OSM #6				
		surance there is a way to get				ting non-
		t to get that medication."				cological
		ne knew about Resident #2,			interver	ntions and

OSM #6 stated, "She should have been given

meds (medications) based on the hospital orders

pain management. .

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CTATEMENT	FOR OFFICIENCIES	CALL EDGLIGHT OF THE STATE OF		<del></del>		DMB NO	<u>). 0938-0391</u>
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETEO
		495362	B. WING	G		0.0	C 9/29/2017
NAME OF	PROVIOER OR SUPPLIER			STRE	EET AOORESS, CITY, STATE, ZIP COOE	1 08	129/2017
ACHLAN	ID NUIDEING AND DE	HADILITATION			THOMPSON STREET		
ASHLAN	ID NURSING AND REI	HABILITATION		1	ILAND, VA 23005		
(X4) IO	SUMMARYSTA	TEMENT OF OFFICIENCIES			<del></del>		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	OBE	IX5I COMPLETION DATE
E 300	Continued From no						<del></del>
1 303	Continued From pa		F3	30 <b>9</b>			
		r ordered." When asked if the			DCS/Designee		
		f was asked to assist in			· , •		· -
	stated they were no	's medications, OSM #6			during Morning	-	
	stated they were no	IL.			Clinical Meeting to	à	
	On 9/28/17 at 2:40	p.m. a message was left with			conduct quality		en Edit i
	a secretary for the i	nfectious disease doctor. The			monitoring daily x4		
		-			weeks, weekly x4		. •
		onducted on 9/28/17 at 3:15			weeks and then		
		the nurse who took off	-		monthly, PRN and		N
		17 infectious disease doctor's database doctor's			• •		_
	followed when a rec	sident returned from a consult			as indicated.		
		3 stated, "Usually that	-				
		orders need to be put on a			4.Findings to be		ļ
	telephone order." W				•		·
		ent #2, LPN #13 stated she	-		communicated to the		·
		ny she did not enter the			QAPI committee		-
		he infectious disease doctor 🕟			monthly and as		
		3 stated she thought the octor wanted to wait until all			indicated. Quality		
	of the resident's lab	oratory work was completed			monitoring schedules		
		When asked if that			modified based on		-
		e documented, LPN #13					
	stated it should be.				findings	-	
	Davies of the about	-11			4. November 14, 2017		
		cian's orders for 6/23/17 did entation regarding holding					· [
	the medication.	rentation regarding holding					ļ
	:	•					· · · .
	Review of the nurse	's note dated 6/23/17 at 8:00					**- * * -
		e documentation regarding				-	
	holding the Triumeq						.*
	•						-
		's note dated 6/28/17					
····		ordered from Infectious	. ***				_

hospital) ordered. Unable to obtain fax #. Will

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O.	JANO APPROVE
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILC		NSTRUCTION		WB NO. 0938-039* (X3) DATE SURVEY COMPLETED
					<del></del>		С
		495362	B. WING				
NAME OF	PROVIOER OR SUPPLIER		<del></del>	STREE	TAOORESS, CITY, STATE, 2	ZIP CODE	09/29/2017
ACULAN	D NUDCING AND DE	ILABII ITATION		1	OMPSON STREET	III COOE	
ASHLAN	D NURSING AND RE	HABILITATION	1	1	AND, VA 23005		
(X4) IO	SUMMARY STA	TEMENT OF OEFICIENCIES					<del></del>
PREFIX TAG	(EACH OEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCEO TO OEFICIENC	TION SHOULO THE APPROPE	BE CONFIGURA
F 309	Continued From pa	ge 109	F3	309	·		
	pass on in report."		, ,	,,,,			
	An interview was co	onducted on 9/28/17 at 3:55 -					. <del>-</del>
		ninistrative staff member) #2,					2
	the director of nursi	ng/clinical services. When					
	asked why the Triur	neq had not been started afte	r			-	÷
	the infectious disea	se doctor ordered it, ASM #2	<u>-</u> _	_			
	stated, "So, (name-	of ASM #5, the physician)					e Territoria
		ve couldn't give it." When					
		6/23/17 infectious disease		•			
	doctor's orders, AS	M-#2 stated; "Well we didn't	•				
		" When asked what would	, = .				· ·
		do, ASM #2 stated they	• - •	-			- 
		ation of the order. ASM #2	<b>-</b>				
	was made aware of	the findings at that time. 🕝	••		-		-,. <del>-</del>
	. A m. fm.t.a.m.d	-1 1 1 000000				.*	4
		anducted on 9/28/17 at 4:05	•				Service of the service
		he resident's doctorWhen	-				ing the end engine
		ent #2's Triumeq, ASM #5 ation was not covered by the-					
	insurance The nurs	es tell me the drugs that	• • • •	. •.		-	
	insurance isn't coup	ring." When asked if that was	-		·		Fig. 7 Fig. 1
	the reason he disco	ntinued the Triumeq, ASM #5	-				10 To 10 To
	stated. "I wasn't sur	e she had HIV. The family					141.72.14
		s∺She wasn't on any :-					
	medication." When	asked why he order the				• •	- '
		ASM #5 did not have an					
		ted, "I wanted her seen by ID					_
·	(infectious disease)	doctors first." When asked-if	·				en eries direction
	he followed the reco	mmendations of the					
	infectious disease d	octors, ASM #5 stated, "Yeah,					¥* 44
		ectious disease) clinic says	-				
		ne." When asked why the	*.				
		rted on 6/23/17 as ordered by	•				
	the infectious diseas	e doctor, ASM #5 stated,		-			-
	"They wanted the lal	os (laboratory specimens)					
	drawn-before they st	arted-it-and-they were going				•	
	to send in their own	lab people." When informed			•		'

the laboratory specimens had been drawn on

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		DNSTRUCTION	OI	(X3) OATE SURVEY COMPLETED
		495362	B. WING				C
	PROVIDER OR SUPPLIER	HABILITATION		906 T	T ADDRESS, CITY, STATE, ZIP CODE HOMPSON STREET AND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C [EACH CORRECTIVE A: CROSS-REFERENCED T( DEFICIE:	CTION SHOULD THE APPROPE	RE COURTETION
F 309	6/28/17, ASM #5 di resident had any ne receiving treatment #5 stated, "No. She	on't reply. When asked if the egative consequence to not for her HIV until 9/13/17, ASM has been diagnosed with tia. It's not reversible but the	F (	309			
·		itive director, and ASM #2, the clinical services, were made		 :			
	Communication of of documented, "12. F following procedure orders. 12.1 Facility contact the resident there is a change in	y's policy titled, er Authorization and Orders to Pharmacy" acility should follow the s with respect to verbal 's licensed nurses should is Physician/Prescriber when condition that may require a a renewal of an existing					
	-	on was provided prior to exit.		· ·			in the late of the
	Complaint deficienc		2.1. 		-	-	
	People who take ab including Triumeq, reaction (hypersens death. This information)	abacavir, an HIV medicine. acavir-containing products, may have a serious allergic itivity reaction) that can cause tion was obtained from: gov/drugs/534/triumeq/0/patie		J-− .			
	by the U.S. Food an	rescription medicine approved d Drug Administration (FDA) HIV infection in adults and age and older. Raltegravir is					

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DEPART	TMENT OF HEALTH	AND HUMAN SERVICES				PRIN	ITED: 10/12/2017
		& MEDICAID SERVICES				FI	ORM APPROVED
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	- 1	NO. 0938-0391 B) DATE SURVEY COMPLETEO
	į	495362	B. WING	3		ı	C
NAME OF	PROVIDER OR SUPPLIER		<del>.!</del>	Τ	STREET ADDRESS, CITY, STATE, ZIP CODE		09/29/2017
ASHLAN	D NURSING AND RE	HABILITATION			906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULDEE	(X5) COMPLETION TE DATE
F 309	Continued From pa	ge 111	<b>□</b>	309			
		bination with other HIV	ι,	JU:	9		
	medicines This info	rmation was obtained from:					
	https://aidsinfo.nih.g	gov/drugs/420/raltegravir/0/pat		-			· -
	ient	**	-				· · · · · · · · · · · · · · · · · · ·
	3 Descovatis athres	scription medicine approved	-		•		
	by the U.S. Food ar	nd Drug Administration (FDA)					<u>-</u> ].
	for the treatment of	HIV infection in adults and				-	
	children 12 years of	age and older who weigh at	·- · .		· · · · · · · · · · · · · · · · · · ·		
	least 77 pounds (35	kilograms). Descovy is	<del>.</del>		_	•	
	aiways used in com	bination with other HIV ormation was obtained from:					- "
		gov/drugs/560/descovy/0/patie					
	nt	govidings/500/descovy/o/patte					
	4. CD4 Count: A lat	poratory test that measures -					
	the number of CD4	T lymphocytes (CD4 cells) in					
	count is the most im	n people with HIV, the CD4 portant laboratory indicator of		-			
	immune function an	d the strongest predictor of	<del>,,</del>	_	-		1 + F <sup>-1</sup> 1 + F
	HIV progression. Th	e CD4 count is one of the					·
	factors used to dete	rmine when to start					
	obtained from the w	(ART). This information was					-
		eosite: ov/understanding-hiv-aids/glo		-	•		
	ssary/822/cd4-count	t-					
	•	<del>-</del>					4 1 TT T- 1.5
	O o The facilities of	f following and the first first to the second			·		#·
	#15's blood process	f failed to obtain Resident = e twice a week, as ordered by	•				
	the physician on 9/2						
				7.			
		dmitted to the facility on					· · · · · · · · · · · · · · · · · · ·
		ses that included but were not					
		schizophrenia, kidney igh blood pressure and					
	etroko Tho moet roe		•				

stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/7/17 coded

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0301

OLIVIE	NO I ON MEDICANE	A MILDICAID SLIVICES				omb n	<u>O. 0938</u> -0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4		CONSTRUCTION	(X3) D	PATE SURVEY OMPLETED
		495362	B. WING			C	C 99/29/2017
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET ILAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT DF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDBE	(X5) COMPLETION DATE
F 309	the BIMS (brief inte indicating the reside make daily decision	ge 112  ving scored a 13 out of 15 on rview for mental status) ent was cognitively intact to as. Resident #15 was coded as e from staff for all activities of	F	309			
	10/4/16 and revised "Focus. The resider perfusion r/t (related	#15's care plan initiated on don 10/19/16 documented, at has potential for alteration in dot) HTN (high blood successions. Vital signs as a needed)."					
÷	documented, "Moni	cian's order dated 9/21/17 tor BP (blood pressure) 2 x il < 140/90) Sunday +					
er Ge	administration recorblood pressure 2x a + Thursday." 9/24/1 indicating the blood	#15's MAR (medication rd) documented, "Monitor week (goal <140/90) Sunday 7 had a box around it pressure was to be obtained was no blood pressure or mented in the box.					
		's notes for 9/24/17 did not ation of the resident's blood			·		
	p.m. with LPN (licen resident's nurse. WI #15's MAR for the 9 #3 stated, "I can't sp the blood pressure vanywhere else, LPN	nducted on 9/28/17 at 12:15 sed practical nurse) #3, the nen asked to review Resident /24/17 blood pressure, LPN beak to that." When asked if would be documented #3 stated, "No, it's only on ked what the empty box on				-	-

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	γ <del>-</del>			ON		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		X3) DATE	SURVEY PLETED
		495362	B. WING				00/3	29/20 <b>1</b> 7
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP COI	DE .	09/2	19/2017
A CHI AN	D NURSING AND RE	HARII ITATION			THOMPSON STREET			
ASIILAN	D NOKSING AND RE	HABILITATION			HLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CRDSS-REFERENCED TO THE AF DEFICIENCY)	HOULD F	BE ATE	(X5) COMPLETION OATE
F 309	On 9/28/17 at 5:00 member) #1, the ac	N #3 stated, "It wasn't done."  p.m. ASM (administrative staff dministrator/executive director,	F3	309				
		rector of nursing/clinical le aware of the findings.	•					
	No further informati	on was provided prior to exit.						
	#15's blood sugar b	ff failed to check Resident efore meals and at bedtime, 7/27/17 physician's orders.						į
	revised on 10/19/16 Resident is at Risk	plan initiated on 10/4/16 and documented, "Focus. The for Metabolic Complications r/tsInterventions. Blood rdered."						
	2017 documented,	cian's orders for September "CHECK BLOOD SUGAR ND AT BEDTIME FOR DM						-
	documented, "CHEO MEALS AND AT BE Further review of the	#15's September 2017 MAR CK BLOOD SUGAR BEFORE DTIME FOR DM. 05/30/17." a MAR revealed that the blood ked on 11 occasions out of 72						
	p.m. with LPN (licentesident's nurse. WI #15's MAR for the p sugars, LPN #3 stat	nducted on 9/28/17 at 12:15 sed practical nurse) #3, the nen asked to review Resident hysician ordered blood ed, "I can't speak to these."						

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FUR OMB N	M WALKOVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D,	O. 0938-0391 ATE SURVEY DMPLETED
		495362	B. WING				C
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION		90	REET ADDRESS, CITY, STATE, ZIP COD 6 THOMPSON STREET 5HLAND, VA 23005	E U	9/29/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	AOULD BE	(X5) COMPLETION DATE
F 309	chart, LPN #3 state asked what the blar stated, "It wasn't do important to obtain LPN #3 stated, "To having a hypoglyce Especially so we kninsulin)."  A telephone intervie at 3:30 p.m. with LF blank space on the "It usually means it  On 9/28/17 at 5:00 administrator/execut director of nursing/daware of the finding  No further information.  3. The facility staff fiphysician's order daware of the finding ware of the finding hyposician's order daware of the finding as 5/18/15 with diagnost limited to: diabetes, and shortness of bre recent MDS, a quart ARD of 7/12/17 codescored a 12 out of 1 mental status indicated cognitively intact to resident was coded assistance from staff	d, No. It's on the MAR." When he spaces meant, LPN #3 one." When asked why it was the resident's blood sugar, make sure that they're not mic (low blood sugar) episode low if we should hold it (the low was conducted on 9/28/17 PN #13. When asked what the MAR meant, LPN #13 stated, wasn't done."  p.m. ASM #1, the tive director, and ASM #2, the clinical services, were made so was provided prior to exit.  ailed to follow Resident #23's the 2/26/17, to check Resident before meals.  dmitted to the facility on ses that included but were not high blood pressure, anemia eath. Review of the most terly assessment, with an ed the resident was make daily decisions. The	F				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: (X3) DATE SURVEY ANO PLAN OF CORRECTION A. BUILOING \_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIÉR STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO IO PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) F 309 Continued From page 115 F 309 requiring the assistance of one staff member. Review of Resident #23's care plan initiated on 2/15/17 and revised on 3/8/17 documented. "Focus. The Resident is at Risk for Metabolic Complications r/t Diabetes, Interventions, Blood Glucose levels as ordered." Review of Resident #23's September 2017 physician's orders documented, "CHECK BLOOD SUGAR BEFORE MEALS DAILY." The order date was 2/26/27. Review of Resident #23's September 2017 MAR documented, "CHECK BLOOD SUGAR BEFORE MEALS DAILY." Further review of the MAR revealed that the resident did not have a blood glucoses done on eight occasions out of 82 opportunities. An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked to review Resident #23's MAR for the blood sugars, LPN #3 stated: "I can't speak to these." When asked if the blood sugars would be documented anywhere else in the resident's chart, LPN #3 stated, No. It's on the MAR." When asked what the blank spaces meant, LPIN #3 stated, "It wasn't done." When asked why it was important to obtain the resident's blood sugar, LPN #3 stated, "To make sure that they're not having a hypoglycemic (low blood sugar) episode. Especially so we know if

we should hold it (the insulin)."

A telephone interview was conducted on 9/28/17. at 3:30-p.m.-with LPN #13, the resident's nurse. When asked what the blank space on the MAR meant, LPN #13 stated, "It usually means it

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION .	(X3) C	OATE SURVEY COMPLETED
		495362	B. WING				C
NAME OF F	ROVIOER OR SUPPLIER		1	STRE	ET AOORESS, CITY, STATE, ZIP CODE	<u> </u>	9/29/2017
					THOMPSON STREET		
ASHLAN	D NURSING AND REI	HABILITATION			LAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	OBE	(X5) COMPLETION OATE
F 309	Continued From pa	ae 116	F 3	na			
	wasn't done."		1 4	103			
	0-00047 + 500	4014 //4 //					
		p.m. ASM #1, the tive director, and ASM #2, the clinical services, were made					
	aware of the finding						
	No further informati	on was provided prior to exit.					
		-					
		ailed to administer Resident					
	multiple dates in Se	on per physician's order on ptember 2017.					
	Resident #17 was a	idmitted to the facility on				•	-, -
		#17's diagnoses included but					
		fractured vertebrae, diabetes esident #17's most recent					
		a set), a quarterly assessment					- : *
	with an ARD (asses	sment reference date) of					
		esident as being cognitively cumented Resident #17					. en m
		ring the five-day look back					<u>-</u> .
	period.	•					· ·
	On 9/27/17 at 2:00 r	o.m. during a group interview,					
	Resident #17 voiced	concern that he was not					
	getting his pain med to.	lication like he was supposed					
		#17's clinical record revealed		. •			
		dated 7/20/17 for Lyrica 75 mg th every eight hours.					
	Resident #17's Sept	ember 2017 MAR					
		tration record) documented					İ
	and 10:00 p.m.	duled for 6:00 a.m., 2:00 p.m.					
							1

Review of Resident #17's Lyrica controlled

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 495362 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 117 F 309 medication utilization record for 8/28/17 through 9/28/17 revealed the medication was not administered to the resident on the following dates/times: -9/1/17 at 6:00 a.m. -9/6/17 at 6:00 a.m. -9/7/17 at 10:00 p.m. -9/9/17 at 2:00 p.m. -9/11/17 time unknown (one pill was signed as being administered at 6:00 a.m. and another pill was signed as being administered on the same day but the time was not documented). Further review of the above Lyrica controlled medication utilization record revealed the medication was available on the above dates and times as evidenced by the previous and latter doses being administered. Further review of Resident #17's clinical record - --(including the back of the MAR, nurses' notes and a leave of absence form) failed to reveal the resident was out of the facility or refused the medication on the above dates/times. Resident #17's comprehensive care plan initiated on 2/10/17 documented, "The resident has alteration in pain/comfort r/t (related to) Disease process...Interventions: Administer analgesia as

needed) ...,"

per orders and prior to treatments or care prn (as

On 9/28/17 at 11:05 a.m. an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked what should be done if a resident has a physician's order for Lyrica every eight-hours. LPN #6 stated, "You have to assess the pain, you might be ODing (overdosing) them." LPN #6 was asked when the medication should

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE		COMPLETED
		495362	B. WING		C 09/29/2017
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHDULD BE COMPLETION
F 309	hours. LPN #6 state given at 6:00 a.m., LPN #6 stated each be documented and medication utilization medication listed or utilization record is discrepancies. Resmedication utilization LPN #6. LPN #6 st He's kind of difficult also went out of the where medication reabsence was docur information should the MAR. Resident and September 201 reviewed with LPN looked like the medication medication reviewed with LPN looked like the medication reviewed with LPN looked like the medication reviewed with LPN looked like the medication medication reviewed with LPN looked like the medication medication reviewed with LPN looked like the medication medication reviewed with LPN looked like the medication and looked like the medication utilization record is stated and looked like the medication utilization record is discrepancies.	ge 118  red scheduled every eight ed the medication should be 2:00 p.m. and 10:00 p.m. a Lyrica pill administered must d counted (in the controlled on record) and each shift the nation that the controlled medication counted so there are not ident #17's controlled medication counted so there are not ident #17's controlled in record was reviewed with ated, "He might have refused." LPN #6 stated the resident facility a lot. When asked efusal and the resident's mented, LPN #6 stated this per documented on the back of #17's September 2017 MAR 7 nurse's notes were #6. LPN #6 was asked if it ication was not administered the above dates, LPN #6		309	
	member) #1 (the ex and ASM #2 (the dir services) were mad concern.  The facility policy titl Guidelines" docume strives to improve p minimize pain in ord maintain his or her hwell-being, PURPO	e.m: ASM (administrative staff ecutive director/administrator) ector of nursing/clinical e aware of the above  ed, "Pain Management ented, "POLICY: The center attent/resident comfort and er to help a resident attain or nighest practicable level of SE: To ensure residents at and care in accordance	- *		
	with professional sta	indards of practice, the plan, and the resident's			

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FORM APPROVED
OMB NO. 0938,0304

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		_		OMR N	O. 0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	4		ONSTRUCTION	(X3) O	O. 0930-0391 PATE SURVEY OMPLETEO
		495362	B. WING				С
NAME OF	PROVIOER OR SUPPLIER				ET ACCRECA CITY AT THE	0	9/29/2017
	ID NURSING AND RE	HABILITATION		906 T	ET AOORESS, CITY, STATE, ZIP COO THOMPSON STREET LAND, VA 23005	E.	
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F 309	Continued From pa	ge 119	F;	309			
	No further informat	on was presented prior to exit.					
		eri ude predented prior to exit.	•				· •
	5 T) 6 Ym - 66	·-					4 4
	5. The facility staff	failed to administer Resident					
	#32's pain and anxi physician's order or		-				_=
	physicians order of	17730717.			,		r writer the
	Resident #32 was a	dmitted to the facility on			<del>.,</del>	-	~ · · · · · · · · · · · · · · · · · · ·
	5/26/17. Resident	#32's diagnoses included but	•				e Santa e Land
	were not limited to:	anxiety disorder, disease of					
	the spinal cord and	osteomyelitis (1). Resident					e de Berger
	muarterly assessme	IDS (minimum data set), a nt with an ARD (assessment	**		-		1.000 00 00 <u>0.2.2</u> 5% 0.00
	reference date) of 9	/12/17, coded the resident as	•		_		and the same of the
	being cognitively int	act. Section J documented					ie i Nation II see ui
	Resident #32 receiv	ed scheduled and as needed					
	pain medication dur	ing the five-day look back					
-	seven on a scale fro	frequent pain rated as a -					
	Severi on a scale in	on zero to teri.					
	Review of Resident	#32's clinical record revealed		-	•		
	a physician's order of	dated 5/26/17 for OxyContin					
	(2) 30 mg (milligram	s) by mouth every eight .					
	hours. Resident #3:						7, 47, 54, 7
	the medication was	tration record) documented scheduled for 6:00 a.m., 2:00					water three in the
	p.m. and 10:00 p.m.	OxyContin 30 mg was					*
	initialed and circled	(indicating the medication			•		
	was not administere	d) on 7/30/17 at 2:00 p.m.	-				
		e- the resident may have			-		
	was due).	when the 10:00 p.m. dose	~	-			10 20
		#32's OxyContin controlled		-			
	medication utilization	record (a record of					-
	documentation that a	accounts for each pill) for 1/17 revealed the last pill in					

that supply of OxyContin was administered at

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FUI 4 DMD	KIM APPROVED
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) (	NO. 0938-0391 OATE SURVEY COMPLETEO
		495362	B. WING				C
	PROVIDER OR SUPPLIER ID <b>NURSING AND RE</b>	HABILITATION		906	EET AOORESS, CITY, STATE, ZIP COO THOMPSON STREET HLAND, VA 23005	<u>                                  </u>	09/29/2017
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE API OEFICIENCY)	IOH O RE	IX5I COMPLETION DATE
F 309	controlled medicati	7. Per the next OxyContin on utilization record, the next administered to Resident #32	F3	309			
	order for Xanax (3) six hours. Residen documented the me 6:00 a.m., 12:00 p.i Xanax 0.5 mg was at 6:00 a.m., 12:00 a.m. The back of th 12mn (12:00 a.m.) mouth) Rx (Pharma 7/30/17 6am (initials script." Review of Resident medication utilization 7/29/17 revealed the Xanax was adminis Per the next Xanax utilization record, the	dated 5/26/17 documented an 0.5 milligrams by mouth every t #32's July 2017 MAR edication was scheduled for m., 6:00 p.m. and 12:00 a.m. initialed and circled on 7/30/17 p.m., 6:00 p.m. and 12:00 ne MAR documented, "7/30/17 (initials) Xanax 0.5mg PO (by acy) called need hard script. (b) 0.5mg PO need hard #32's Xanax controlled n record for 7/22/17 through the last pill in that supply of tered on 7/29/17 at 6:00 p.m. controlled medication e next dose of Xanax sident #32 was on 7/30/17 at					
	"Resident alert & ve Resident upset PRN scheduled medication approval. Resident stated he was going face when he see (s medication alternation Writer called on call was not going to sig refused wound care Called pharmacy to	d 7/30/17 documented, rbal oriented X (times) 3. I (as needed) and 1 of ons are awaiting doctor became verbally abusive and to punch Dr. (name) in the sic) him. Writer offered other we and resident refused. doctor and he said 'no' he n any hard scripts. Resident X 2-at 10-am-& 1:15 pm see if writer can pull					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	MAPPROVED
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	JX2) MU A. BUILO		CONSTRUCTION	(X3) O/	O. 0938-0391 ATE SURVEY DMPLETEO
		495362	B. WING	·			C
	PROVIOER OR SUPPLIER  D NURSING AND REI	HABILITATION		906	REET AOORESS, CITY, STATE, ZIP COOE THOMPSON STREET HLAND, VA 23005	10:	9/29/2017
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	ıx	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	IDBE	IX5I COMPLETION OATE
F 309	needed hard scripts Resident stated sind medications he wan of Nursing aware."	s. Spoke with (name), ce he don't (sic) have any pain ats to go to hospital. Director	F;	309			
	The EMS (emergency medical services) patient report dated 7/30/17 documented, "Time call received: 1541 (3:41 p.m.) Chief Complaint: BACK PAIN- ON PAIN MGT (management) PROTOCOL. FACILITY OUT OF OXY (OxyContin)" The hospital records dated 7/30/17 documented, "52 year paraplegic male presents to the ED (emergency department) c/o. (complaint of) pain at his R (right) ischial area, rated 10/10, since today. Pt (Patient) reports that his nursing home ran out of his Rx (prescription) OxyContin and Xanax, which has happened multiple times in the past, and he has not had any meds (medications) today" Further review of the hospital records revealed Resident #32 was administered Oxycodone 30 mg Xanax 0.5 mg in the hospital.						
	"Resident return (sic from Hospital, stated Resident was medica (medication) upon re in from pharmacy at in bed with no s/s (signales)	7/31/17 documented, ) from Hospital. Nurse called I she gave him OxyContin. aled with his scheduled med turn. Xanax and OxyContin 8:20 pm. Resident is resting gns or symptoms) of ats. No distress noted."					
' {	on 6/7/17 documente alteration in pain/com	nfort r/t (related to) Right nd. Chronic back pain,					

depression...Interventions: Anticipate the resident's need for pain relief and respond to any

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPR	OVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURY COMPLETE	/EY
		495362	B. WING _		C 09/29/20	117
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	<u></u>
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTIDN SHOULD BE COMF TO THE APPROPRIATE 0	XSI PLETION ATE
F 309	Continued From pa	iae 122	F 30	0		
	complaint of pain	_	1 30	9		
	conducted with Res	0 a.m. an interview was sident #32. Resident #32 e were times when his ot available.				
,	conducted with LPN LPN #5 was asked ensuring medicatio when a week's wor is left, she obtains a physician and faxes pharmacy. LPN #5 lot of medication. L nurses may not pay medication supply gime it takes for the medication. LPN #6 insurance will declined.	p.m. an interview was I (licensed practical nurse) #5. the facility process for a availability. LPN #5 stated the of the supply of medication a hard prescription from the stated Resident #32 takes a PN #5 stated sometimes the vattention when the gets low and don't realize the pharmacy to deliver 5 stated sometimes the ne allowing the pharmacy to not if it's ordered too early.				
	conducted with ASM member) #5 (Resid was made aware ROXYContin was not 7/30/17 because the prescription. ASM # seeking. He wants to get his kick." ASOCCURRED ON a week was needed then the medication (due	p.m. an interview was M (administrative staff ent #32's physician). ASM #5 esident #32's scheduled available for administration on a facility staff needed a hard #5 stated, "The guy is drug his breakthrough medication M #5 stated if this situation end and a hard prescription e physician could not call in to controlled substance if a hard prescription could				

be faxed to the pharmacy on a weekend, ASM #5 stated, "Where are you going to fax it from?" ASM #5 stated he and the facility staff take care

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STATEMENT OF DEFICIENCES  AND PLAN OF CORRECTION  AND PROVIDER OR SUPPLIER  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND NURSING AND REHABILITATION  ASHAND AND ASSAURT STATEMENT OF DEFICIENCES (EACH DEFICIENCE) AND ASHAND AND ASSAURT ASSAURT AND	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMR NO	M APPROVED
ASHLAND NURSING AND REHABILITATION  SIMMARY STATE LIP CODE  906 THOMPSON STREET ASHLAND, VA 23005  FREGULTORY OR LSC IDENTIFYING REPORTATION)  FREGULTORY OR LSC IDENTIFYING REPORTATION)  FREGULTORY OR LSC IDENTIFYING REPORTATION)  FROUNDERS PLAN OF CORRECTION SHOULD BE CASTED THAT TAG CROSS-REFERENCED TO THE AFFROPMATE OF DEFICIENCY  F 309 Continued From page 123  of hard prescriptions on Thursdays and Fridays, and this situation rarely occurs. ASM #5 stated, "What can I do?" ASM #5 was read the portion of the 77/30/17 nurse's note that documented the on-call physician stated he would not sign a hard prescription. ASM #5 stated medications that are signed and circled on the MAR indicate the medications were not administered. LPN #6 stated medications should be documented on the back of the MAR.  On 9/28/17 at 4:30 p.m. another interview was conducted with Resident #32. The resident was reluctant to talk. Resident #32 was asked if he felt comfortable describing how he feels when he doesn't receive his medication. Resident #32 stated he was in a car accident when he was 18 years old, has had eight back surgeries, multiple leg surgeries and degenerative joint disease. Resident #32 stated he feels pain 24 hours a day and he immediately tanks when he doesn't receive his pain medication. When asked to explain what that meant, Resident #32 stated feeling him 24 hours a day and he immediately tanks when he doesn't receive his pain medication. When asked to explain what that meant, Resident #32 stated feeling him 24 hours a day and he immediately tanks when he doesn't receive his pain medication. When asked to explain what that meant, Resident #32 stated feeling him pain on top of these symptoms is horifying. Resident #32 was made aware his clinical record had been reviewed and				1			(X3) DA	ATE SURVEY
ASHLAND NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY RECHIDENCY MUST BE PRECEDED BY PULL AFFOLL DEFICIENCY TAG  CROSS-MEPERENCE OT OTHE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  Fag CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE  PROVIDERS OTT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPRIATE DEFICIENCY  FAG CROSS-MEPERENCE OT OT THE APPHOPPINATE  FAG CROSS-MEPERENCE OT OT THE APPHOPPINATE  FAG CROSS-MEPERENCE OT OT THE APPHOPPINATE  PROVIDERS OTT OT THE APPHOPPINATE  PROVIDERS OTT OT THE APPHOPPINATE  FAG CROSS-MEPERENCE OT THE APPHOPPINATE  FAG CROSS-MEPERENCE OT THE APPHOPPINATE  FAG CROSS-MEPERENCE OT THE APPHOPPINATE  FAG CROSS-MEPERENCE OTT OTT OF  FAG CROSS-MEPERENCE OTT OTT OF  FROM TAG CROSS-MEPERENCE OTT OT			495362	B. WING	;		0,	
ASHLAND NURSING AND REHABILITATION    SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PERCEDED BY PULL TAGE   PROVIDER'S PLAN OF CORRECTION (FACH CORRECTION CHAPTER)	NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<del></del>	ST	REET ADDRESS CITY STATE ZIR CODE	1 05	3/29/2017
OCI) D SLAMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 309 Continued From page 123 of hard prescriptions on Thursdays and Fridays, and this situation rarely occurs. ASM #5 stated, "What can I do?" ASM #5 was read the portion of the 730/17 nurse's note that documented the on-call physician stated he would not sign a hard prescription. ASM #5 stated, "Yeah, so this was a weekend."  On 9/28/17 at 4:25 p.m. an interview was conducted with LPN #6. LPN #6 stated and circled on the MAR indicate the medications were not administered. LPN #6 stated an explanation should be documented on the back of the MAR.  On 9/28/17 at 4:30 p.m. another interview was conducted with Resident #32. The resident was reluctant to talk. Resident #32 was asked if he felt comfortable describing how he feels when he doesn't receive his medication. Resident win the was 18 years old, has had eight back surgeries, multiple leg surgeries and degenerative joint disease. Resident #32 stated he was nedicately tanks when he doesn't receive his pain medication. When asked to explain what that meant, Resident #32 stated "It feels like hot barbed wire running up the length of my leg. Just spinning in there." Resident #32 stated he also experiences symptoms of withdrawal including hot and cold sweats, shaking and the loss of bowel/bladder function. Resident #32 stated feeling the pain on top of these symptoms is horrifying. Resident #32 was aware his directle record had been reviewed and	ASHLAN	D NURSING AND RE	HABILITATION		90	6 THOMPSON STREET		
of hard prescriptions on Thursdays and Fridays, and this situation rarely occurs. ASM #5 stated, "What can I do?" ASM #5 was read the portion of the 7/30/17 nurse's note that documented the on-call physician stated he would not sign a hard prescription. ASM #5 stated, "Yeah, so this was a weekend."  On 9/28/17 at 4:25 p.m. an interview was conducted with LPN #6. LPN #6 stated medications that are signed and circled on the MAR indicate the medications were not administered. LPN #6 stated an explanation should be documented on the back of the MAR.  On 9/28/17 at 4:30 p.m. another interview was conducted with Resident #32. The resident was reluctant to talk. Resident #32 was asked if he felt comfortable describing how he feels when he doesn't receive his medication. Resident #32 stated he was in a car accident when he was 18 years old, has had eight back surgeries, multiple leg surgeries and degenerative joint disease. Resident #32 stated he fels pain 24 hours a day and he immediately tanks when he doesn't receive his pain medication. When asked to explain what that meant, Resident #32 stated he lass of the resident #32 stated he lass of some plan in the resident #32 stated he also experiences symptoms of withdrawal including hot and cold sweats, shaking and the loss of bowel/bladder function. Resident #32 stated feeling the pain on top of these symptoms is hortriging. Resident #32 was made aware his clinical record had been reviewed and	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO	JLD BF	COMPLETION
order for as needed Oxycodone (4). Resident		of hard prescription and this situation ra "What can I do?" A the 7/30/17 nurse's on-call physician structure prescription. ASM weekend."  On 9/28/17 at 4:25 conducted with LPN medications that are MAR indicate the madministered. LPN should be document on 9/28/17 at 4:30 conducted with Resreluctant to talk. Refelt comfortable desidoesn't receive his stated he was in a cyears old, has had eleg surgeries and de Resident #32 stated and he immediately receive his pain me explain what that me feels like hot barbed my leg. Just spinning stated he also expensively and the loss of bower #32 stated feeling the symptoms is horrifying aware his clinical resthis surveyor saw the	is on Thursdays and Fridays, arely occurs. ASM #5 stated, ASM #5 was read the portion of note that documented the ated he would not sign a hard #5 stated, "Yeah, so this was a p.m. an interview was A #6. LPN #6 stated e signed and circled on the redications were not #6 stated an explanation ated on the back of the MAR.  p.m. another interview was esident #32. The resident was esident #32 was asked if he scribing how he feels when he medication. Resident #32 car accident when he was 18 eight back surgeries, multiple egenerative joint disease. If he feels pain 24 hours a day tanks when he doesn't dication. When asked to eant, Resident #32 stated "It if wire running up the length of ang in there." Resident #32 riences symptoms of the pain on top of these ing. Resident #32 was made cord had been reviewed and at he also had a physician's	F	309			

#32 was asked why he wasn't willing to accept the as needed Oxycodone when the OxyContin

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				FURI OMB NO	M APPROVED <u>0. 0938-</u> 0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DA	O. 0938-0391 ATE SURVEY OMPLETED
····		495362	B. WING _				C 9/20/2017
	PROVIDER OR SUPPLIER  ND NURSING AND RE			90	REET ADDRESS, CITY, STATE, ZIP CODE 16 THOMPSON STREET SHLAND, VA 23005	0:	9/29/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	_	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD RE	JX5) COMPLETION DATE
F 309	was not available. pointless to take the	age 124  The resident stated it was ne short acting Oxycodone cting OxyContin because it	F 30	09			
:	conducted with ASI nursing/clinical service facility process for a availability. ASM #2 changed and narco prescription from the as nurses approach narcotic medication doctor to collaborat getting low on a me prescription. ASM # follow up with the docur if a resident redication. ASM # follow up with the docur if they can admit because most resident orders for other me if the physician coul Sunday to write a harmonic service in the service of the physician coul Sunday to write a harmonic service as the service of	in p.m. an interview was M #2 (the director of vices). ASM #2 was asked the ensuring medication #2 stated that process has obtic medications require a hard the physician. ASM #2 stated the running out of a resident's in, nurses should contact the te and let him know they are redication and need a #2 was asked what should runs out of a narcotic #2 stated the nurses should doctor or the on-call doctor to ininister another medication dents have PRN (as needed) redications. ASM #2 was asked ald come to the facility on a nard prescription and fax the pharmacy. ASM #2 stated,					
	member) #1 (the ex	a.m. ASM (administrative staff xecutive director/administrator) made aware of the above					į
	No further informati	ion was presented prior to exit.					
		a bone infection. This tained from the website:	-				

https://kidshealth.org/en/teens/osteomyelitis.html

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		& MEDICAID SERVICES			· .	OMB	NO. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE C	CONSTRUCTION		DATE SURVEY COMPLETED
		495362	B. WING	€			C
	PROVIDER OR SUPPLIER ND NURSING AND REI	HABILITATION		906 7	EET ADDRESS, CITY, STATE, ZIP THOMPSON STREET ILAND, VA 23005	CODE	09/29/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TA(	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5] COMPLETION E DATE
F 309	oral formulation of condicated for the massevere pain when a analgesic is needed time" This inform website: https://dailymed.nlmaDrugInfo.cfm?arch  (3) Xanax is used to information was obthetys://medlineplus.tml  (4) Oxycodone is us severe pain. This in the website: https://www.ncbi.nlmT0011537/  6. The facility staff f medications and tread ordered by the physical resident # 6 was ac 7/14/11 and most red diagnoses that include cancer, anemia, core gastroesophageal reseizure disorder, cer	ets are a controlled-release exycodone hydrochloride anagement of moderate to continuous, around-the-clock of for an extended period of ation was obtained from the a.nih.gov/dailymed/archives/fd iveid=15783  In treat anxiety. This ained from the website: gov/druginfo/meds/a684001.h  ed to treat moderate to formation was obtained from a.nih.gov/pubmedhealth/PMH  ailed to administer atments to Resident # 6 as cian.  Idmitted to the facility on cently on 9/7/17 with ded but were not limited to:	F	309			
	set) assessment, an ARD (assessment re coded Resident # 6 a	recent MDS (minimum data Annual Assessment, with an ference date) of 8/5/17 as understood by others and d others. Resident # 6 was					

### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILOING COMPLETED С 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL IX5ı **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 309 Continued From page 126 F 309 coded as being cognitively impaired for making daily decisions, scoring 4 out of 15 on the BIMS (brief interview for mental status). Review of the physician orders revealed the following documentation: Dated 7/30/16: "REGLAN (2) 5MG (milligram) TAKE 1 TABLET BY MOUTH BEFORE BREAKFAST, LUNCH, DINNER." This order was signed by the physician on 7/1/17 and 8/2/17. Dated 7/30/16: "LIPITOR (3) 10MG TABLET TAKE 1 TABLET BY MOUTH NIGHTLY." This order was signed by the physician on 7/1/17 and 8/2/17. Dated 7/30/16: "DIOVAN (4)160 MG TABLET TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17. Dated 3/20/17: "LEXAPRO (5) 20MG TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17. Dated 1/24/17: "RENA-VITE (6) 0.8MG TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17. Dated 7/30/16: "BRILINTA (7) 90MG TABLET

and 8/2/17.

TAKE 1 TABLET BY MOUTH TWICE DAILY."
This order was signed by the physician on 7/1/17

Dated 7/30/16: "SYNTHROID (8) 200MCG TAKE 1 TABLET BY MOUTH BEFORE BREAKFAST." This order was signed by the physician on 7/1/17

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OLIVIERO POR MEDIOVIRE GIVI			· · · · · · · · · · · · · · · · · · ·			OMB NO	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495362	B. WING	i		n n	C 9/29/2017
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CDDE	1 30	PIZUITOTI
ASHLAN	D NURSING AND REI	HABILITATION		1	THOMPSON STREET		
HONEAN	D HORSING AND KE	MADICITATION		AS⊦	ILAND, VA 23005		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	<u> </u>	<del></del>		
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 300	0- " 15	40**				-	
F 309	Continued From pa	ge 127	F	309			
	and 8/2/17.						
	D : 17/20110 III.0						
	Dated 7/30/16: "NO	RVASC (9) 10 MG TAKE 1					
		H DAILY." This order was					
	signed by the physic	cian on 7/1/17 and 8/2/17.					
	Dated 7/30/16: "XA	LATAN (10) 0.005% DROPS					;
	ADMINISTER 1 DR	OP TO BOTH EYES					
		der was signed by the					
	physician on 7/1/17						
		PPRA (11) 100MG TAKE 1					
		H DAILY." This order was					
	signed by the physic	cian on 7/1/17 and 8/2/17.					
	Datad 3/20/17: "DD	OTONIX (12) 40MG TABLET					
	TAKE 1 TABLET BY	MOUTH EVERY DAY." This					
		the physician on 7/1/17 and					
	8/2/17.	, are projection on the first and					
		PIRIN 81 MG TAKE 1 TABLET					
		" This order was signed by					•
	the physician on 7/1	/17 and 8/2/17.					
	Dated 7/30/16: "CO	LACE (12) 100MG TAKE 1					
		TH DAILY." This order was					
		cian on 7/1/17 and 8/2/17.					
	- <b>3</b> - <b>3</b> - <b>7</b> - <b>7</b> - <b>7</b> - <b>1</b>						
		NENLA (13) 800MG TABLET					
		00 MG) BY MOUTH THREE					
		s order was signed by the					
	physician on 7/1/17	and 8/2/17.					*
	"CHECK FASTING!	BLOOD SUGAR EVERY DAY					1
		4:30 PM." This order was					
		cian on 7/1/17 and 8/2/17.					
<del></del>							į
	Review of the MAR	(medication administration					

record) for Resident # 6 revealed lack of

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES ΙD PROVIDER'S PLAN OF CORRECTION {X5} PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 309 Continued From page 128 F 309 documentation for the following: For July 2017: Reglan was not given at 6:30 a.m. seven times out of 31 opportunities. Reglan was not given at 10:00 a.m. three times out of 31 opportunities. Reglan was not given at 3:00 p.m. seven times out of 31 opportunities. Lipitor was not given at 9:00 p.m. one time out of 31 opportunities... Lexapro was not given at 9:00 a.m. one time out of 31 opportunities. Rena-Vite was not given at 9:00 a.m. one time out of 31 opportunities. Brilinta was not given at 5:00 a.m. one time out of 31 opportunities. Check fasting blood sugar at 6:30 a.m. was not done two times out of 31 opportunities. Check fasting blood sugar at 4:30 p.m. was not done one time out of 31 opportunities. For August 2017: Synthroid was not given three times out of 31 opportunities. Reglan was not given at 6:30 a.m. two times out of 31 opportunities. Reglan was not given at 10:00 a.m. six times out of 31 opportunities.

opportunities.

of 31 opportunities.

of 31 opportunities.

Reglan was not given at 3:00 p.m. four times out

Norvasc was not given at 9:00 a.m. four times out

Aspirin not given at 9:00 a.m. four times out of 31

Colace not given at 9:00 a.m. four times out of 31 opportunities.

Keppra not given at 9:00 a.m. four times out of 31

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) OATE SURVEY IDENTIFICATION NUMBER: A. BUILOING COMPLETED 495362 B. WING: NAME OF PROVIOER OR SUPPLIER 09/29/2017 STREET AOORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO Ol PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE OEFICIENCY) F 309 Continued From page 129 F 309 Diovan not given at 9:00 a.m. four times out of 31 opportunities. Renvela not given at 7:30 a.m. four times out of 10 opportunities. Renvela not given at 11:30 a.m. five times out of 10 opportunities. Renvela not given at 4:30 a.m. two times out of 10 opportunities: Lipitor was not given at 9:00 p.m. four times out of 31 opportunities. Xalatan was not given at 9:00 p.m. five times out of 31 opportunities. Lexapro was not given at 9:00 a.m. five times out of 31 opportunities. Protonix was not given at 9:00 a.m. four times out of 31 opportunities. Rena-Vite was not given at 9:00 a.m. two times out of 31 opportunities. Brilinta was not given at 9:00 a.m. four times out of 31 opportunities. Brilinta was not given at 5:00 a.m. four times out of 31 opportunities. Check fasting blood sugar at 4:30 p.m. was not done nine times out of 31 opportunities. Nurses notes for July and August 2017 were reviewed and no notation as to why the medications were not given could be found. During an interview on 9/28/17 at 8:40 a.m. with LPN (licensed practical nurse) # 10, LPN # 10 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 10 stated that technically it meant that staff did not

do it - "Not documented not done."

During an interview on 9/28/17 at 8:50 a.m. with LPN # 9, LPN # 9 was asked what it meant if there were blocks on the MAR that had no initials

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					3 NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495362	B. WING	i			С		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CO	ODE	09/29/2017		
ASHLAN	D NURSING AND REI	HABILITATION		906	THOMPSON STREET HLAND, VA 23005	ODE			
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(XS) COMPLETION TÉ GATE		
F 309	inside. LPN#9 sta	ited that staff might have till it is not signed then it is not	F	309					
	ASM (administrative director of nurses/c was shared. ASM # the MARs meant. A documented it is no was asked to identifurses could be interested.	on 9/28/17 at 10:47 a.m. with e staff member) # 2, the linical services, this concern + 2 was asked what blanks on ASM # 2 stated that if it is not t given. At this time ASM # 2 fy the nurses' initials so those erviewed. A request for the owing physician orders was ne.							
	LPN # 6, a unit man what it meant if ther that had no initials ir is a hole in the MAR given. LPN # 6 iden were missing initials were interviewed. During an interview	on 9/28/17 at 1:20 p.m. with ager, LPN # 6 was asked e were blocks on the MAR iside. LPN # 6 stated if there then the medication was not attified three of the nurses that on the MARs in question: all							
	During an interview of LPN #8, LPN #8 stameans that the med During an interview of ASM #1, the admini	on 9/28/17 at 3:30 p.m. with ated that if there are blanks it ication was not given: on 9/28/17 at 4:50 p.m. with strator/executive director and r of nurses/clinical services,							
	Review of the policy	that was presented did not							

address the concern of this citation.

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOING \_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOF 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO Ю PROVIDER'S PLAN OF CORRECTION EACH OFFICIENCY MUST BE PRECEOSO BY FULL PREFIX (X5) COMPLETION [EACH CORRECTIVE ACTION SHOULO BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE OATE OEFICIENCY) F 309 Continued From page 131 F 309 No further information was presented prior to exit. References: (1) Cerebral palsy-- a group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpals y.html. (2) REGLAN -- Metoclopramide is an oral prokinetic and antiemetic agent used in the therapy of gastroesophageal reflux disease. gastroparesis and severe or chemotherapy induced nausea. This information was obtained from the website: https://livertox.nlm.nih.gov/Metoclopramide.htm (3) LIPITOR -- Atorvastatin is used together with a proper diet to lower cholesterol and triglyceride (fats) levels in the blood. This medicine may help prevent medical problems (e.g., chest pain, heart attack, or stroke) that are caused by fats clogging the blood vessels. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

from the website:

T0009143/?report=details

T0012601/?report=details-

(4) DIOVAN -- Valsartan and hydrochlorothiazide

https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

(5) LEXAPRO -- Escitalopram is used to treat

combination is used alone or with other medicines to treat high blood pressure (hypertension). This information was obtained

DEPAR	TMENT OF HEALTH	AND HUWAN SERVICES				PRINTE	D: 10/12/2017
		& MEDICAID SERVICES				FORM	APPROVED
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DA	). 0938-0391 TE SURVEY MPLETED
		495362	B. WING	3_			С
NAME OF	PROVIDER OR SUPPLIER		<u></u>	Τ	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/29/2017
ASHLAN	ID NURSING AND RE	HABILITATION			906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	X5  COMPLETION OATE
F 309	Continued From pa	ge 132	F:	309	9		<del></del>
·	(GAD). It is an antic group of medicines reuptake inhibitors work by increasing serotonin in the bra This information wa https://www.ncbi.nlrT0010165/?report=(6) RENA-VITE S	is obtained from the website: m.nih.gov/pubmedhealth/PMH details tupplies your body with vitamin					
	B and vitamin C. Yo because of an illnes are using. This inforwebsite:	nu might need extra vitamins is or other medicines that you mation was obtained from the n.nih.gov/pubmedhealth/PMH			·		٠.
	drug that is used wit decrease the risk of stroke in patients wi This information wan https://livertox.nlm.n	grelor) is an oral antiplatelet th low dose aspirin to myocardial infarction and th acute coronary syndromes. s obtained from the website: iih.gov/Ticagrelor.htm					
	hypothyroidism, a co- gland does not prod Levothyroxine is also size of enlarged thyr goiter) and to treat the This information was	s obtained from the website: n.nih.gov/pubmedhealth/PMH	·		- -		**
		llodipine is used alone or nedicines to treat angina			·		

(chest pain) and high blood pressure

(hypertension). This information was obtained

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG CATE DEFICIENCY) F 309 Continued From page 133 F 309 from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0008948/?report=details (10) XALATAN -- Latanoprost is used to treat certain kinds of glaucoma. It is also used to treat a condition called hypertension of the eye. Latanoprost appears to work by increasing the outflow of fluid from the eye. This lowers the pressure in the eye. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010869/?report=details (11) KEPPRA -- Levetiracetam is used to help control certain types of seizures in the treatment of epilepsy. This information was obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010898/?report=details (12) COLACE -- Stool softener -- relieves occasional constipation (irregularity). This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/archives/fd aDrugInfo.cfm?archiveid=124986 (13) RENENLA -- Lowers the amount of phosphorus in blood of patients receiving kidney dialysis. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0012110/?report=details

ordered by the physician.

7...The facility staff failed to administer ... medications and treatments to Resident # 7 as

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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NAME OF I	PROVIDER DR SUPPLIER	}		STREET ADDRESS, CITY, STATE, ZIP CO	09/29/2017 DE
ASHLAN	ND NURSING AND RE	EHABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
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F 309	Continued From pa	age 134	F 309	9	
	3/28/13 and most r diagnoses that incl diabetes, dementia disorder, chronic o	admitted to the facility on recently on 3/10/17 with cluded but were not limited to: a, hypertension, bipolar obstructive pulmonary disease, aucoma, and irritable bowel			
	set) assessment, a an ARD (assessme coded Resident #7 as able to understa coded as being co	st recent MDS (minimum data a Quarterly Assessment, with tent reference date) of 8/5/17 7 as understood by others and and others. Resident # 7 was ognitively intact for making daily 15 out of 15 on the BIMS (brief al status).			
	Review of the phys following documen	sician orders revealed the ntation:			
	100/ML (milliliter) II SUBCUTANEOUS THREE TIMES DA 152-200 = 2 UNITS 251-300=6 UNITS, 351-400=10 UNITS GREATER THAN A BLOOD SUGAR IN SLIDING SCALE O BLOOD SUGAR IN 450, FOLLOW SLI	UMALOG (1) KWIKPEN INSULIN PEN INJECT SEY PER SLIDING SCALE AILY IF BLOOD SUGAR IS S, 201-250=4 UNITS, I, 301-350=8 UNITS, S, 401-450=12 UNITS, 450=14 UNITS AND REPEAT N 2 HOURS AND FOLLOW COVERAGE, IF REPEAT N 2 HOURS AND STILL OVER IDING SCALE AND CALL MD."			
<del></del>	· Dated-3/10/1-7-*iP/	RATROPIUM-ALBUTEROL	_		

(2)... INHALE 1 UNIT DOSE VIA NEBULIZER THREE TIMES DAILY..." This order was signed

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 309 Continued From page 135 F 309 by the physician on 7/1/17 and 8/2/17. Dated 3/10/17: "LANTUS (3)...INJECT 30 UNITS SUBCUTANEOUSLY EVERY EVENING ... " This order was signed by the physician on 7/1/17 and 8/2/17. Dated 3/10/17: "LASIX (4) 40 MG (milligram) TAKE 1 TABLET BY MOUTH EVERY DAY ..." This order was signed by the physician on 7/1/17 and 8/2/17... Dated 4/26/17: "DEPAKOTE (5) 500 MG TAKE 1 TABLET BY MOUTH EVERY EVENING." This order was signed by the physician on 7/1/17 and 8/2/17. Review of the MAR (medication administration record) for Resident #7 revealed lack of documentation for the following: For July 2017: Sliding Scale Insulin blood sugar not checked at 11:30 a.m. three times out of 31 opportunities. Sliding Scale Insulin blood sugar not checked at 4:30 p.m. one time out of 31 opportunities. Ipratropium-Albuterol not given at 9:00 a.m. one time out of 31 opportunities, Ipratropium-Albuterol not given at 1:00 p.m. two times out of 31 opportunities. Ipratropium-Albuterol not given at 5:00 p.m. two

For August 2017:

times out of 31 opportunities.

Sliding Scale Insulin blood sugar not checked at 11:30-a.m. one-time out-of-31 opportunities.——Sliding Scale Insulin blood sugar not covered with

insulin at 11:30 a.m. one time out of 9

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETEO C 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION IX5I COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 309 Continued From page 136 F 309 opportunities. Sliding Scale Insulin blood sugar not checked at 4:30 p.m. two times out of 31 opportunities. Sliding Scale Insulin blood sugar not covered with insulin at 4:30 p.m. five times out of 12 opportunities. Lantus not given two times out of 31 opportunities. Ipratropium-Albuterol not given at 1:00 p.m. one time out of 31 opportunities. Ipratropium-Albuterol not given at 5:00 p.m. two times out of 31 opportunities. Lasix was not given one time out of 31 opportunities. Depakote was not given one time out of 31 opportunities. $\tilde{I}_{c}$ Nurses notes for July and August 2017 were reviewed and no notation as to why the $\widetilde{\mathcal{G}}_{2}$ ing t medications and treatments were not given could be found. During an interview on 9/28/17 at 8:40 a.m. with LPN (licensed practical nurse) # 10, LPN # 10 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 10 stated that technically it meant it was not done... "Not documented not done." During an interview on 9/28/17 at 8:50 a.m. with

LPN # 9, LPN # 9 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 9 stated that staff might have forgotten to sign but if it is not signed then it is not

During an interview on 9/28/17 at 10:47 a.m. with ASM (administrative staff member) # 2, the

done - staff have to document.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE SURVEY CDMPLETED
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NAME OF	PROVIDER OR SUPPLIER	<u> </u>	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE	09/29/2017
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE COMPLETION
F 309	Continued From pa	age 137	F 30	19	
1	was shared. ASM	clinical services, this concern # 2 was asked what blanks on ASM # 2 stated that if it is not-			
_	documented it is no was asked to ident	of given. At this time ASM # 2 ify the nurses initials so those erviewed. A request for the	<u>.</u>		
		owing physician orders was			
	LPN # 6, a unit man what it meant if the that had no initials is a hole in the MAI given. LPN # 6 ide	on 9/28/17 at 1:20 p.m. with nager, LPN # 6 was asked re were blocks on the MAR nside. LPN # 6 stated if there R then the medication was not ntified three of the nurses that is on the MARs in question: all	_		
- 18 m		on 9/28/17 at 1:30 p.m. with tated that if there is a blank was given.	-		
-	LPN #8, LPN #8 s	on 9/28/17 at 3:30 p.m. with tated that if there are blanks it dication was not given.			
	ASM # 1, the admir and ASM # 2, the di	on 9/28/17 at 4:50 p.m. with istrator/executive director, rector of nurses/clinical rn was again shared.			
	Review of the policy address the concern	that was presented did not of this citation.	- ·		
	No further information	on was presented prior to exit.			
<del></del>	References:-	·			
	(1) Humalog® [insul	in lispro injection, USP (rDNA			

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILOING COMPLETEO C 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION JX5J COMPLETION PREFIX (EACH OEFICIENCY MUST BE PRECEOSO BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULO BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) F 309 Continued From page 138 F 309 origin)] Insulin lispro is a fast-acting type of insulin. Insulin is one of many hormones that the body turn the food we eat into energy. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010736/ helps (2) IPRATROPIUM-ALBUTEROL Ipratropium and albuterol combination is used to help control the symptoms of lung diseases, such as asthma. chronic bronchitis, and emphysema. It is also used to treat air flow blockage and prevent the worsening of chronic obstructive pulmonary disease (COPD) in patients who need another medicine. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010776/?report=details (3) LANTUS(Insulin glargine) is a long-acting type of insulin that works slowly, over about 24 hours. Insulin is one of many hormones that help the body turn the food we eat into energy. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010731/?report=details (4) LASIX - furosemide tablet Furosemide belongs to a group of medicines called loop diuretics (also known as water pills). Furosemide is given to help treat fluid retention (edema) and swelling that is caused by congestive heart -failure, liver disease, kidney disease, or other medical conditions. This information was

obtained from the website:

(5) DEPAKOTE --Valproic acid is used to treat

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  D NURSING AND R		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	[ U	9/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		IJI O RE	(X5) COMPLETION DATE	
F 309	medicine is an ani brain tissue to sto used to treat the medicine in the medicine migraine headach obtained from the https://www.ncbi.m. T0012594/?report 8. The facility staff saturation levels in levels dropped belonged by the belonged belonged by the belonged belonged by the belonged belonged by the belonged belonged by the belonged belonged by the belonge	sizures (epilepsy). This ticonvulsant that works in the p seizures. Valproic acid is also nanic phase of bipolar disorder e illness), and helps prevent es. This information was website:  Ilm.nih.gov/pubmedhealth/PMH = details  failed to obtain oxygen order to notify the physician if low 90 % for Resident #16.  admitted to the facility on loses that included but were not muscle spasms of the back, estructive pulmonary disease) chronic nonreversible lungually a combination of chronic bronchitis (1)), BPH inspertrophy) (Benign prostatic alled BPH-is a condition in men ate gland is enlarged and not a prostatic hypertrophy or benign on (2)), restless leg syndrome,	F	309			
 	admission assessing reference date of the being cognitively in the resident was to extensive assist all of his activities Special-Treatment	MDS (minimum data set), an ment, with an assessment 7/25/17, coded Resident #16 as ntact to make daily decisions. coded as requiring supervision rance of one staff member for of daily living. In Section O -s., Procedures and Programs, ot coded as having a CPAP* or Lipment.	- *** - -				

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILOING \_\_\_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF OFFICIENCIES PROVIDER'S PLAN OF CORRECTION OI IX5) COMPLETION PRÉFIX (EACH OFFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULO BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE **OEFICIENCY**) F 309 Continued From page 140 F 309 \* C-PAP, Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep aonea. A C-Pap machine increased air pressure in the throat so that the airway does not collapse when you breathe in. (3).Review of the clinical record revealed a physician order dated 7/27/17, which documented, "O2 (oxygen) @ (at) 2 L/MIN (liters per minute) via nasal cannula for comfort; notify MD (medical doctor) if O2\* drop under 90%. \*Pulse oximetry is a noninvasive monitoring technique used to estimate the measurement of arterial oxygen saturation (SaO2,) of hemoglobin. (4).Review of Resident #16's MARS (medication) administration records) for September 2017 documented in part, "O2 @ 2 L/MIN via nasal cannula for comfort; notify MD if O2\* drop under 90%." The nurses signed with their initials but there was no documentation of the O2 saturation. levels. Further review of the clinical record failed to evidence documentation of the resident's O2 saturation levels. The comprehensive care plan dated 7/26/17 documented, in part, "Focus: The resident has

the potential for an ineffective breathing pattern r/t (related to) GERD (gastroesophageal reflux disease), COPD, hx (history) of smoking and dyspnea (difficulty breathing)." The "Interventions" documented, in part, "Oxygen as ordered." Resident #16's care plan, further documented, in part:-"Focus:-The resident has the potential for alteration in perfusion r/t COPD, arrhythmias, hypertension (high blood pressure)." The

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	-	& MEDICAID SERVICES				0!	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA  IOENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION		(X3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, 2	ZIP CODE	03/23/2011
40011 441	D MUDOWA AND DE	tank (mamos)			THOMPSON STREET		
ASHLAN	D NURSING AND REI	HABILITATION			ILAND, VA 23005		
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F 309	S/S (signs and sym	umented in part, "Monitor for ptoms) of decreased cardiac	F;	309			
	dizziness, shortnes syncope. Notify phy	anges in pulse, weakness; s of breath, edema, lethargy, vsician of any change in lung og edema. Vital signs as s needed)."	-	-			- -
	practical nurse) #16 above physician ord When asked if the r levels (O2 sats) sho	onducted with LPN (licensed on 9/27/17 at 3:40 p.m. The der was reviewed with heresident's oxygen saturation ould be checked per the order, I have to research that and get			·		/ <u>.</u> -
	surveyor that the fa getting an order to o (as needed) oxyger and the O2 Sats, w stated, "Yes, it is." V	p.m. LPN #16 stated to this cility was in the process of discontinue Resident #16's prn n." When asked if the oxygen ere a current order, LPN #16 When asked if the O2 pe documented, LPN #16 n."					
	conducted with adm (ASM) #2, the direct ASM #2 was asked order. When asked documented, ASM adocumented if he with above MAR was When asked if the boxygen was administration levels do	p.m. an interview was ninistrative staff member tor of nursing/clinical services. to review the above physician if O2 sats should be #2 stated, "They should be as going to use the oxygen." as reviewed with ASM #2. soxes were signed as if stered, should there not be O2 cumented, ASM #2 stated, ess of changing that order:"		•			v

The executive director/administrator, (ASM #1),

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CENTERS FOR MEDICARE & MEDICAID SERVICES  OMB NO. 0938-0391							
STATEMENT OF 0 E FICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING				(X3) OATE SURVEY COMPLETEO
		495362	B. WING	·			C
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ASHLAND NURSING AND REHABILITATION				906	THOMPSON STREET ILAND, VA 23005	3332	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCEO TO TI OEFICIENCY	ON SHOULO HE APPROPE	BE COMPLETION
F 309	and ASM #4 the reg services, were mad on 9/27/17 at 5:23   (1) Barron's Diction	or of nursing/clinical services gional director of clinical le aware of the above findings o.m.  ary of Medical Terms for the er, 5th edition; Rothenberg and	F:	309			_
	(2) BPH This inform following website: https://www.niddk.rogic-diseases/prosta (3) This information following website: www.webmd.com/s (4) Grap MJ. Pulse for Practice: Technology.	nation was obtained from the ih.gov/health-information/urel ate-problems/prostate-enlarge	-				
	orders and apply a right hand splint to la right hand splint to la Resident #12 was a 8/12/15 with diagno limited to: enlarged weakness, hypothyr (chronic obstructive Resident #12's mos set) was a quarterly (assessment refere Resident #12 was compaired in cognitive	failed to follow physician's left hand palm protector and a Resident #12's hands.  Idmitted to the facility on ses that included but were not prostate, heart failure, muscle roidism, dementia, and COPD pulmonary disease). It recent MDS (minimum data assessment with an ARD nice date) of 7/11/17. Oded as being severely a function scoring 03 out of 15 interview for Mental Status)—					
		2 was coded as requiring total		•-		**	

dependence on one staff member with dressing,

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CTATEMENT	OF DEFICIENCIES	(X4) PDOMPEDICUPDI (EDIOLIA	4400	=		<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING	<u> </u>		C 09/29/2017
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 03/23/2017
ASHLAN	D NURSING AND REI	HABILITATION		906 T	THOMPSON STREET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN DF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UIDBE COMPLETION
F 3 <b>0</b> 9		ge 143 unit, eating, and bathing; and be from one staff member with	F	309	·	
,	made of Resident # his hands at his sid appeared to be slig was under the cove was not wearing a point of the coverage of the	p.m., an observation was #12. He was lying in bed with e. The fingers to his left hand htly contracted. His right hand ers and was not visible. He palm protector to his left hand.  a.m., an observation was #12. He was lying in bed with e. The fingers to his left and ed to be slightly contracted, g a splint or palm protector to				
	made of Resident # his hands at his sid right hands appeare	5 a.m., an observation was 1412. He was lying in bed with e. The fingers to his left and ed to be slightly contracted. If a splint or palm protector to	<u>-</u>			
	made of Resident # his hands at his side appeared to be slig was under the cove	5 p.m., an observation was 12. He was lying in bed with e. The fingers to his left hand htly contracted. His right hand rs and was not visible. He palm protector to his left hand.		 -	· ·	_ T
	made of Resident # his hands at his side appeared to be slight was under the cove	p.m., an observation was 12. He was lying in bed with e. The fingers to his left hand htly contracted. His right hand rs and was not visible He halm protector to his left hand	•		· ·	- -

		AND HUMAN SERVICES					PRINTE	D: 10/12/201	7
		& MEDICAID SERVICES	<del>,</del>	<u> </u>			OMB N	M APPROVE O. 0938-039	D 11
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	_	(X3) D	ATE SURVEY OMPLETED	-
		495362	B. WING			<del></del>		C 9/ <b>29</b> /2 <b>017</b>	
NAME OF F	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, S	STATE, ZIP CODE		3/29/2017	┥
ASHLAN	D NURSING AND RE	ABILITATION			THOMPSON STREE ILAND, VA 23005	Т			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S P (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTIVE ACTION SHO CED TO THE APPR FICIENCY)	III D RE	(X5) COMPLETION OATE	4
F 309	Continued From pa	ge 144	F3	309					$\dashv$
	On 9/28/17 at 10:30 made of Resident#	a.m., an observation was 12. He was not wearing his d or his right hand splint.	-					·	
	sheet) signed by the documented the foll splints on during the removed. Left hand	#12's POS (physician order ephysician on 8/28/17, owing orders: "Right hand day, check skin once palm protector on at all for hygiene, skin checks, ery shift."				,		- · · · · · · · · · · · · · · · · · · ·	-
	care plan dated 8/3 following interventio as ordered. Right h	#12's "Impaired skin integrity" 1/16, documented the ns: "Left hand palm protector and splint as ordered." were initiated on 2/2/17.							
	Information Kardex" "Splint: R (right) han	t recent "Nursing Tech documented the following: d/palm protectors." The htion Resident #12's palm and.							-
-	(treatment administr (no signatures) unde	#12's September 2017 TAR ation record) revealed blanks or the following treatment: on during the day check skin						<del>-</del> - 1 + - 1 + - - 1 + - 1 + - - 1 + - 1	
	revealed initials or si	e September 2017 TAR gnatures on 9/26/17 for 3-11 7-3 and 3-11 shifts indicating int was in place.							
	On 9/28/1 <b>7</b> 11:05 a.r	n., an interview was							

conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked if Resident #12 was supposed to have a splint to

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) D	O. 0938-0391 DATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STRE	ET AODRESS, CITY, STATE, ZIP COOE	<u> </u>	9/29/2017
ASHLAN	D NURSING AND REI	HABILITATION		906	THOMPSON STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR DEFICIENCY)	JI D BE	(X5) COMPLETION OATE
F 309	hand, LPN #10 look and stated that he	a palm protector to his left ked at his physician's orders was supposed to have splints ked if they were in place, LPN	F	309			
	#10 stated that initial completed. When a (no signatures) for the Resident #12's Sep "That is supposed that e supposed in the suppose	nitials meant on the TAR, LPN als meant that a treatment was asked why there were blanks the right hand splint on tember TAR, LPN #10 stated, o just be an FYI." When nitials documented on 9/27/17 ft documenting that Resident ector was in place, LPN #10 n asked if his palm protector 7/17, LPN #10 stated, "No. I we circled my initials."					
	splints, and palm pr CNAs put on the sp ensure the splints a asked to review Res surveyor. LPN #10 #12's Kardex. Whe know to put a palm left hand if it is not of LPN #10 stated that information in a vert #10 accompanied the room. LPN #10 con	ras responsible for putting on rotectors; LPN #10 stated the lints and the nurses have to re in place. LPN #10 was sident #12's Kardex with this showed this writer Resident in asked how CNA's would protector to Resident #12's documented on the Kardex, t CNA's would get that pal report. At this time LPN his surveyor to Resident #12's ector were not in place.					
	conducted with CNA #4, Resident #12's (	a.m., an interview was A (certified nursing assistant) CNA. When asked how what to put into place for skin					-

preventive measures etc., CNA #4 stated that she

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CENTEF	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES					0. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA	O. 0938-039° ATE SURVEY DMPLETED
		495362	B. WING			1	C 9/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	_	9/29/2017
ASHLAN	ID NURSING AND RE	HABILITATION		906	THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X5) COMPLETION OATE
F 309	would get report from When asked if she documented reside there is, I don't known on 9/28/17 at 5:15 staff member) #1, the director and ASM # Nursing)/clinical set above concerns.  A policy could not be 9b. The facility staff non-pharmacologic the administration of #12; failed to assess prior to the administroto document the eff was administered to Review of Resident sheet) dated 8/28/1 orders: "Morphine Smilliliters) Solution, mouth/under tongue pain/SOB (shortness Code status: D.N.R. Comfort Care."	om the nurses or other CNAs. had a reference to use that had a reference to use that ent needs, CNA #4 stated, "If ow where it is."  p.m., ASM (administrative the administrator/executive £2, the DON (Director of rvices were made aware of the deep provided.  If failed to attempt that pain interventions prior to of Morphine [1] to Resident as pain location and intensity tration of Morphine and failed fectiveness of Morphine after it to the resident.  If #12's POS (physician order 7, documented the following Sulfate 20 MG/1ML (milligram/0.25 ml (milliliters) by every 2 hours as needed for as of breath). If (DO NOT RESUSCITATE)	F 3	09	DEFICIENCY)		
	record) revealed that Morphine 20 MG on	nedication administration at Resident #12 received in 7/7/17 at 6 p.m., 7/10/17 at 5 p.m., 7/24/17 at 10:00 a.m. 0/17 at 6 p.m.	-		-		

Further review of the July 2017 MAR failed to

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			<u>-</u>		NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		495362	B. WING	;			C 09/29/2017
	PROVIDER OR SUPPLIER  O NURSING AND RE		. <del></del> _	906	REET ADDRESS, CITY, STATE, ZIP COD 6 THOMPSON STREET SHLAND, VA 23005	<u>;</u> E	03/23/20 11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 309	reveal non-pharma attempted prior to the assessments docur of pain prior to the follow up pain asses administration of M. Review of the July reveal documentati interventions attem of Morphine to Resassessments docur of pain prior to the assessments docur of pain prior to the assessments docur of pain prior to the after the administrative further review of the revealed a note data the following: "Resi and Ativan [2] 0.25.  The above note did non-pharmacologic prior to the adminis location of pain, and to determine the eff.  On 9/27/17 at 11:05 conducted with LPN #10, Resident #12's the process followe (as needed) pain mishe would first find location of pain and	acological pain interventions the administration of Morphine, menting location and intensity administration of Morphine and essments after the Morphine.  2017 nursing notes failed to ion of non-pharmacological noted prior to the administration sident #12 on the above dates, menting location and intensity administration of Morphine on the follow up pain assessments action of Morphine.  The July 2017 nursing notes that 7/15/17 that documented ident given Morphine 0.25 ml ml pain of 6/10 (6 out of 10)"  In not document that interventions attempted stration of Morphine, the indication of Morphine of Morphine, the indication of Morphine of Morp		309			
	non-pharmacologic	cal interventions are not					

effective, she would administer the pain

medication and do a follow up pain assessment.

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		A MEDICAID SERVICES	<del></del>			OMB NO	). 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY CDMPLETED		
		495362	B. WING				С	
NAME OF	PROVI <b>O</b> ER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODI	09	/29/2017	
V SHI VY	ID NURSING AND RE	UADII ITATIONI			THOMPSON STREET	=		
ASILAN		MADILITATION			HLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE	
F 309	the administration of non-pharmacologic offered and the followed be documented in a flow sheet. When a non-pharmacologic on hospice, LPN #1 #10 could not deter completed for Residual administration of M documented above determine if non-phwere attempted price	at the pain assessment prior to	F3	309			-	
	attempted with Res understand the que On 9/28/17 at 5:15 staff member) #1, the director/administration	or and ASM #2, the DON				-	-	
	(Director of Nursing aware of the above	)/clinical services were made concerns.				٠		
	Guideline" documer "Purpose: To ensure treatment and care professional standar comprehensive care choices related to paldentification: Evaluation admission/re-admission condition, or with evaluation: Identify in							

0-10 scale) or for those patient/residents who

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) O.	ATE SURVEY
		495362	B. WING			С
	PROVIDER OR SUPPLIER		1	STREET AOORESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005		9/29/2017
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		HOULO BE	IX5) COMPLETION DATE
F 309	cannot self-report, indicators. The pai equivalent to be ma Administration Rec Develop patient cel (pharmacologic and manage pain. Doc care plan. Monitorin patient/resident's re Evaluate the effecti and progress towar interventions and offamily/resident reproplan as indicated."  [1] Morphine is a na alleviate moderate information was ob Institutes of Health. https://www.ncbi.nli. T0001216/. [2] Ativan-used to trinformation was ob Institutes of Health. https://www.ncbi.nli. T0010988/?report=10. The facility staff order to keep Residelevated on two pill in a chair.  Resident #10 was a 5/2/13 with a readming of the control of the c	use the non-verbal clinical in flow record or electronic aintained in the Medication ord (MAR). Treatment: Intered interventions of non-pharmacologic) to ument interventions on the ng: Monitor and document the esponse to interventions of goals. Discuss new oals with the resident and/or resentative. Update the care arcotic pain reliever used to to severe pain. This tained from The National m.nih.gov/pubmedhealth/PMH reat anxiety disorders. This tained from The National m.nih.gov/pubmedhealth/PMH reat anxiety disorders. This tained from The National m.nih.gov/pubmedhealth/PMH reat anxiety disorders. This tained from The National m.nih.gov/pubmedhealth/PMH reat anxiety disorders. This tained from The National dent #10's bilateral lower legs ows when in bed and seated admitted to the facility on hission date of 9/14/14 with uded, but were not limited to: swallowing, convulsions,	F	309		

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		ECONSTRUCTION	(X3) O	ATE SURVEY OMPLETEO
  -		495362	B. WING	·		,	C 09/29/2017
NAME OF I	PROVIOER OR SUPPLIER			SI	FREET ADORESS, CITY, STATE, ZIP COOE		70/23/2017
ASHLAN	D NURSING AND REI	HABILITATION		90	06 THOMPSON STREET SHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES ( MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCEO TO THE APPRI OEFICIENCY)	LOBE	X5  COMPLETION DATE
F 309	(assessment refered Resident #10 as be BIMS (brief intervier assessment of Reswas coded as a "3" Resident #10 was swith daily decision realso coded as requione to two staff meliving and as rarely understood when concluded the second when concluded the	sessment with an ARD ence date) of 7/6/17, coded eing unable to complete the w for mental status). The staff sident #10's cognitive status (three) indicating that severely cognitively impaired making. Resident #10 was iring extensive assistance of mbers for all activities of daily understanding or being ommunicating with others.  Observed lying in his bed with bed and without pillows under on the following dates and 00 p.m. and 4:40 p.m., a., 8:36 a.m., 8:47 a.m. and 9/28/17 at 8:40 a.m.  Observed seated in a hair on 9/27/17 at 11:45 a.m., p.m.  of #10's physician orders and order dated 6/8/17, "Order the lower extremities two (sic) in bed or seated."  of #10's physician order 1/17 revealed, in part, the ation; "8/3/17: ELEVATE TIES TWO PILLOW HIGHT OOR SEATED." Signed by		309			
	A review of Resider	nt #10's TAR (treatment			·		

administration record) dated 9/1/17 - 9/30/17 revealed, in part, the following documentation;

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		& MEDICAID SERVICES	<del></del>		0	MB NO	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495362	B. WING				C 9/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 0:	9/29/2017
Verity	D NURSING AND RE	HADII ITATION			THOMPSON STREET		
AUTILAN	B NONSING AND RE	,	•	ASF	HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) RF	(X5) COMPLETION DATE
F 309		OWER EXTREMITIES TWO	F;	309			
	revealed, in part, th	nt #10's progress notes e following documentation; Elevate lower extremities two n bed or seated."	<u>-</u> .		<del>-</del>		<del></del>
	conducted with CN. #11, a nursing aide CNA #11 was asked what was on a resid know how to care fix care plan items were communication tool special needs. CN. needs Resident #10 care. CNA #11 stated the kardex. CNA # stated Resident #10 wore "hipsters" hip of his hips. CNA #11 direction to elevate extremities on two p seated. CNA #11 and the #10's room and corlower extremities we pillows and there we or in his room. The under Resident #10	p.m. an interview was A (certified nursing assistant) working with Resident #10. d to state how she would know dent's care plan so she would or a resident. CNA #11 stated re placed on the kardex (a d) so they could refer to that for A #11 was asked what special d) had in regards to his daily red she would have to refer to 11 reviewed the kardex-and d) was dependent on care and protectors worn on either side 1 was asked if there was any Resident #10's lower foillows when in bed and when tated there was not. At this his writer went into Resident affirmed that Resident #10's tere not elevated on two the remaining the pillow observed is head.					
·• •	conducted with LPN a floor nurse working	p.m., an interview was I (licensed practical nurse) #3, g with Resident #10. LPN #3 as aware of a physician order					

to elevate Resident #10's lower extremities on

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	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER;	(X2) MUI A. BUILO		E CONSTRUCTION	(X3) O	OMPLETED
		495362	B. WING	·		,	C )9/29/2017
NAME OF F	PROVIOER OR SUPPLIER			S	TREET AOORESS, CITY, STATE, ZIP COOE	_!	0012012011
ASHLAN	D NURSING AND RE	HABILITATION		1 .	06 THOMPSON STREET SHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG	ΙX	PROVIOER'S PLAN OF CORREC [EACH CORRECTIVE ACTION SHOI CROSS-REFERENCEO TO THE APPR OEFICIENCY)	JLOBE	IX5I COMPLETION DATE
F 309	two pillows while lyi stated she was not physician orders we LPN #3 then stated On 9/28/17 at 7:30 staff member) #1, t director/administrat findings. A policy we following physician On 9/28/17 at 8:40 observed lying in hi on the bed. Reside elevated on two pilli observed to be on the behind the resident On 9/28/17 at 10:15 what should happen order. LPN #3 state ordered." LPN #3 worder to elevate Refollowed as ordered am not sure why."  A review of the facil Orders" did not revergarding following	ng in bed or seafed. LPN #3 At this time Resident #10's ere reviewed with LPN #3 and she would "take care of it."  a.m., ASM (administrative he executive or, was made aware of these was requested regarding orders.  a.m. Resident #10 was a bed with his lower legs flatent #10's legs were not ows and there were no pillows he bed other than one pillow	F:	309	OEFICIENCY)		
	end of the survey pr In "Fundamentals o Patricia A. Potter an Inc; Page 419 "The			-			

obligated to follow physician's orders unless they believe the orders are in error or would harm

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING	<b>;</b>		С
NAME OF F	PROVIDER OR SUPPLIER		L		STREET ADDRESS, CITY, STATE, ZIP CODE	09/29/2017
ASHLAN	D NURSING AND REI	HABILITATION		5	906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSED FOR COMMON	BE COMPLETION
F 30a	Continued From no	an 153			1.Resident #4 is	
1 303	Continued From pa clients."	ge 153	F;	309	currently receiving daily	
F 314	483.25(b)(1) TREAT	TMENT/SVCS TO	F:	314	wound care service and	
	PREVENT/HEAL P			. , ,	is also being followed by	-
	(b) Skin Integrity -	•			the wound care	
	(b) Skiii intogrity -				Physician weekly.	
	(1) Pressure vicers				Resident #4is currently	
	facility must ensure	essment of a resident, the that-			has a pressure	
	-				redistribution mattress	
		es care, consistent with rds of practice, to prevent			in place as well as a	
		i does not develop pressure			pressure redistribution	-
	ulcers unless the in-	dividual's clinical condition			cushion in his wheel	· [
	demonstrates that t	hey were unavoidable; and		- •	chair. Resident #4 is	
		ressure ulcers receives			currently receiving	-
		It and services, consistent with rds of practice, to promote			supplements to	
		ection and prevent new ulcers			promote wound	
	from developing.	•			healing. Resident #4 has	
	This REQUIREMEN	IT is not met as evidenced			been educated and	
	Based on staff inter	rview, facility document review			encouraged to decrease	, .
		eview, it was determined that			time sitting in	
		d to provide treatment and and and promote healing of a			wheelchair in order to	
	pressure ulcer for o	ne of 34 residents in the			promote wound	
	survey sample, Res	ident #4.	•		healing. Resident	,
		ed to provide treatment to	•		#4'scare plan has been	ļ
_		ure sores on several nd for six consecutive days in			updated to reflect	
		lity staff failed notify the			wound location, type,	
	wound care nurse of	f Resident #4's pressure			treatment,	- '
		et which time the wound was mented as two wounds. The			interventions and	
		outtock/ischium was identified	-		resident education.	
					resident Education,	

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CENTER					FORM.	APPROVED
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY IPLETED
		495362	B. WING			C
NAME OF F	A BUILDING  495362  B. WING  ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 154  and documented as a stage III pressure ulcer and the wound on the left hip was identified and documented as an unstageable pressure ulcer.  The findings include:  Resident #4, a 47 years old was admitted to the facility on 7/20/15 with a readmission on 10/30/15 with diagnoses that included, but were not limited to: schizophrenia (a group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts and disturbances of thought, language, perception and emotional response (1)), paraplegia, edema, suicide attempt, traumatic brain injury, high blood pressure and drug overdose.  The most recent MDS (minimum data set) assessment, a quarterly assessment, with an		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>U9/</u> 2	29/2017	
ASHLAN	ID NURSING AND RE	HABILITATION	9	906 THOMPSON STREET ASHLAND, VA 23005		
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) HE APPROPRIES	2.05	(X5) COMPLETION OATE
F 314	Continued From pa	age 154	F 314	The state of the s		
	and documented as	s a stage III pressure ulcer and		2.A quality review of		
	the wound on the le	eft hip was identified and		current residents with		
	documented as an	unstageable pressure ulcer.		pressure ulcers has		
				been performed. A		
	The findings include	e:		quality review of TAR's		
				of current residents has		
	facility on 7/20/15 w	vith a readmission on 10/30/15		been performed. A		•
	with diagnoses mail to: schizophrenia (a	. included, but were not limited a croun of mental disorders		quality review of skin of		
	characterized by gro	ross distortions of reality,		current residents in the		
				facility has been	•	-
	response (1)), paraj	plegia, edema, suicide		performed. Follow up		•
	attempt, traumatic b	brain injury, high blood		based on findings.		
				3.Licensed Nurses re-		_
	assessment referen	nce date (ARD) of 8/28/17,		educated by		
		as being cognitively intact to s. Resident #4 was coded as		DCS/Designee regarding		
	requiring extensive	assistance for most of his.		following Physician		
	activities of daily living	ing. In Section M - Skin		orders regarding wound		
		dent was coded as having one for and one Stage IV		care implementation		• •
	pressure ulcer. The	dimensions of the unhealed		and treatment. Licensed		
	Stage III or Stage IV	/ pressure ulcer were cm (centimeters) in length,		Nurses re-educated by		
	8.6 cm in width, and	d 5.4 cm in depth. It was		DCS/Designee regarding		
		black, brown or tan tissue		following Physician		-
		to the wound bed or ulcer er or harder than surrounding		orders on documenting		
	skin".			on Treatment	-	İ
		nent MDS assessment, with vas reviewed and did not code		Administration Record	•	

Resident #4 in Section M as having any pressure

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			0'	MRURI MR AM	MAPPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DA1	). 0938-0391 TE SURVEY MPLETED
		495362	B. WING			00	C
NAME OF F	PROVIDER OR SUPPLIER		<del>'</del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	/29/2017
ASHLAN	ID NURSING AND RE	.HABtL!TATtON		90	06 THOMPSON STREET SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	IX5  COMPLETION DATE
F 314	Continued From pa	age 155	F 3	14			
	ulcers.				(TAR). DCS/Designee		
	The "Braden Scale	for Predicting Pressure Sore	-		during Morning Clinic		•
	Risk" dated, 1/26/1	7, 4/9/17 and 8/22/17,			Meeting to conduct		•
	documented the Re	esident #4's score as a "17." A es the resident is "at risk" for			quality monitoring of	:	
	developing pressur				skin assessments and		
	- '				TARs daily 4 weeks,		
		n Observation Form"  CNAs (certified nursing			weekly x4 and then		•
	assistants) and sigr	ned by a nurse, dated 6/1/17,			monthly, PRN and as		
		documented, "No new			indicated.		en en en en en en en en en en en en en e
		ontained a diagram of the documented on the drawing of					, .
	the body. The "Skin	n Observation Form" dated, -	-		4.DCS/Designee to		
 	6/19/17, documents	ed, "Resident stated old cut his sliding board." The			conduct quality		
ī		on the form documented a			monitoring regarding		
l.	circle around the rig	ght lower buttock and			physician notification		
l.		ding." The "Skin Observation 17 documented, "Open are			with documentation i		
:		' An "X" was documented on					
	the diagram of the b	body on the form, under the			the medical record as		
		"Skin Observation Form" mented a check mark next to,			indicated. Findings to		
		mented a check mark next to, le was documented on the			communicated to the		
	forms body diagram	n below the right buttock and			QAPI committee		
	written next to it was	s: "Open, bleeding sore." The Form" dated 7/2/17,			monthly and as		- ·
	documented a chec	ck mark next to "open area."			indicated. Quality		• -
	Also written on the f	form was "Open Area/			monitoring schedules		•
		vas drawn around the lower	•		modified based on		
		on the right side on the forms "Skin Observation Form"			findings		
	dated 7/6/17 did not	t have any documentation			5.November 14, 2017		
	other that a check mas no signature of	nark next to "bed bath." There		•	•		
	was no signante or	a Hurse.					

The "Weekly Skin Integrity Review" sheets were

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  A 95362  NAME DEPROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION  PHEN 17AC  POPULATION 17AC  F 314  Continued From page 156 reviewed. These are completed by the nurse assigned to the resident. The form documented, "Indicate site(s) with an "X." The following was documented: "Weekly Skin Integrity Review" - 6/12/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/5/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/5/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/5/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/5/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/5/17 - An X was placed next to "Open area." Handwritten on document." TX (treatment) in place." There were no marks on the diagram of the b	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMBA	NO. 0938-0391
ASHLAND NURSING AND REHABILITATION    STREET ADDRESS, CITY, STATE, ZIP CODE   906 THOMPSON STREET   ASHLAND, VA 23005				1			(X3) E	DATE SURVEY
ASHLAND NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION REGULATORY ORLSC IDENTIFYING INFORMATION)  F 314  Continued From page 156 reviewed. These are completed by the nurse assigned to the resident. The form documented, "Indicate site(s) with an "X." The following was documented: "Weekly Skin Integrity Review" - 6/12/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/36/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/3/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/3/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/6/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/6/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.			495362	B. WING				
Summary STATEMENT OF DEFICIENCES  (PACH) DEFICIENCY MUST BE PRECEDED BY PILL  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  (EACH DEFICIENCY)  F 314	NAME DF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	(	09/29/2017
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314 Continued From page 156 reviewed. These are completed by the nurse assigned to the resident. The form documented, "Indicate site(s) with an "X." The following was documented: "Weekly Skin Integrity Review" - 6/12/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/26/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/26/17 - An X was placed next to "Open area." Handwritten n document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/3/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/6/17 - An X was placed next to "Open area." Handwritten n document, "TX (treatment) in place." There were no marks on the diagram of the body.	ASHLAN	D NURSING AND RE	HABILITATION					
reviewed. These are completed by the nurse assigned to the resident. The form documented, "Indicate site(s) with an "X." The following was documented:  "Weekly Skin Integrity Review" - 6/12/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/19/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." Acircle was documented over the right buttock on the body diagram.  "Weekly Skin Integrity Review" - 6/26/17 - An X was placed next to "Open area." Handwritten n document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/3/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.  "Weekly Skin Integrity Review" - 7/3/17 - An X was placed next to "Open area." Handwritten n document, "TX (treatment) in place." There was a circle documented under the left buttock on the body diagram.  "Weekly Skin Integrity Review" - 7/16/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI)		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ILDEE	COMPLETION
was placed next to "Open area." Handwritten on the document was the following: "TX (treatment)	F 314	reviewed. These a assigned to the res "Indicate site(s) with documented: "Weekly Skin Integrous placed next to document, "TX (treatocument, "TX (treatocumented over the diagram.  "Weekly Skin Integrous placed next to document, "TX (treatocument,  completed by the nurse ident. The form documented, h an "X." The following was rity Review" - 6/12/17 - An X "Open area." Handwritten on atment) in place." There were agram of the body.  rity Review" - 6/19/17 - An X "Open area." Handwritten on atment) in place." A circle was he right buttock on the body  rity Review" - 6/26/17 - An X "Open area." Handwritten number area." Handwritten number area." Handwritten number area." Handwritten number area." Handwritten on atment) in place." There were agram of the body.  rity Review" - 6/30/17 - An X "Open area." Handwritten number area." Handwritten number area." Handwritten number atment) in place." There was distributed under the left buttock on the city Review" - 7/6/17 - An X "Open area." Handwritten on atment) in place." There were agram of the body.  rity Review" - 7/6/17 - An X "Open area." Handwritten on atment) in place." There were agram of the body.	F 3	314				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OV	1B NO. 0938	-0301
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURV	/EY
į		495362	B. WING				C	47
NAME OF F	PROVIOER OR SUPPLIER		<del></del>	STR	EET ADORESS, CITY, STATE, ZIP	CODE	09/29/20	17
ASHLAN	D NURSING AND REI	HABILITATION		906	THOMPSON STREET HLAND, VA 23005	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD I E APPROPR	SF COMP	X5) PLETION ATE
F 314	"Weekly Skin Integr was placed next to document was the place." There was left buttock on the buttock on the buttock on the buttock on the buttock on the back on the body di "Weekly Skin Integr was placed next to back on the body di "Weekly Skin Integr was placed next to document was the flace." There was aboth left and right buttock. There was placed next to placed next to placed next to placed next to placed next to placed next to standard to the document was two circles document was two circles document was the flace." This is the document was placed next to placed next to placed next to placed next to placed next to standard to the document was the flace. This is the document was the flace of the document was two circles document was the flace. This is the flace of the f	as a circle documented under he body diagram.  Tity Review" - 7/17/17 - An X  "Open area." Handwritten on following: "TX (treatment) in a circle documented under the body diagram.  Tity Review" - 7/24/17 - An X  "Open area." Handwritten on the following: "TX (treatment) as an X over the sacral/lower agram.  Tity Review" - 7/31/17 - An X  "Open area." Handwritten on following: "TX (treatment) in a circle documented under futtocks on the body diagram.  Tity Review" - 8/7/17 - An X  "Open area." An X was following: there were as the following: there were first documentation that sure areas on the Weekly w.  e's notes did not evidence		314	DEFICIENCY)			
	any nurse's notes from the floor nurses.  The wound care nur	om 6/12/17 until 7/17/17 by se documented on 7/6/17, no Resident has open area under						

buttocks/ischium measures 3.0 x 2.0 x 0.1 cm (centimeters). The left buttock/hip measures 2.9 x

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		& MEDICAID SERVICES	τ		OM	B NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC	TIPLE CONSTRUCTION	l l	X3) DATE SURVEY COMPLETED
		495362	B. WING			C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	ZIP COOF	09/29/2017
ACHIAN	D NURSING AND RE	UADII ITATION		906 THOMPSON STREET	.,	
AOHEAN		HADILHAHON		ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD B O THE APPROPRIA	IX5) E COMPLETION ATE DATE
F 314	Continued From pa	age 158	F:	314		
	•	ulation tissue and skin noted	, ,	-		
		tment orders put in place. RP				
		& MD (medical doctor) made				
		eatment in place. Resident sit for long period of time in				
		nd take rest periods from sitting				
	ín w/c."					
	The "Proceure Hier	or Pagarda" datad 7/6/17				
1	documented, "Left."	er Records" dated 7/6/17, huttock/hip: Stage:				
		surements (cm): L (length) 2.9				
		O (depth) 0.1." There was		•		
		d under the tissue type, wound				
ļ	was signed by the	r periwound area. The form wound care nurse.				· · · •
				•		
į		essure Injury: Obscured -				
	full-thickness skin a	and tissue loss and tissue loss in which the				
		nage within the ulcer cannot				
·	be confirmed becau	use it is obscured by slough or				ļ
		r eschar is removed, a Stage				-
		re injury will be revealed. dry, adherent, intact without				
		nce) on the heel or ischemic			-	
	limb should not be	softened or removed. (2)				
	The "Pressure Hice	r Records" dated 7/6/17,				, l
		t Buttock/ischium: Stage: 3;				
		) L 3.0 x W 2.0 X D 0.1. There				• •
		ented under tissue type,				
		rage or periwound area. The rather the wound care nurse.				İ
		Injury: Full-thickness skin				
	loss Full-thickness loss (	of skin, in which adipose (fat)				
		r and granulation tissue and				

epibole (rolled wound edges) are often present.

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CENTE	KO FOR WEDICARE	& MEDICAID SERVICES				OMB	NO. 0938-0391
	OF OE FICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION		3) OATE SURVEY COMPLETEO
		495362	B. WING				C
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STR	EET AOORESS, CITY, STATE, ZIP COO		09/29/2017
ΔSHI ΔΝ	D NURSING AND REI	HARII ITATIONI		1	THOMPSON STREET	=	
KOITEKI					HLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG	ΊX	PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE APP OEFICIENCY)	OULOBE	(X5) COMPLETION E DATE
F 314	Continued From pa	ae 159	_				
	Territoria de la companya de la companya de la companya de la companya de la companya de la companya de la comp	ar may be visible. The depth	F	314			
	of tissue damage va	arinay be visible. The depth aries by anatomical location;					-
	areas of significant	adiposity can develop deep		-			
	wounds. Undermin	ing and tunneling may occur.					
	Fascia, muscle, ten	don, ligament, cartilage					
	and/or bone are not	exposed. If slough or eschar					-
	obscures the extent	of tissue loss this is an					
	Unstageable Pressi	ure Injury. (3)					
!	The Wound Care P	hysician notes dated, 7/24/17,	~				,
	documented in part	"Left Hip Unstageable (Due					
	to necrosis). Wound	Size: 5.7 x 6.8 x 0.1. Thick	- •				
	adherent devitalized	I necrotic tissue: 100%.					
	Pressure Wound of	the Right Ischium: 5.3 x 4.2 x					-
	0.1. Granulation: 80	%; Skin: 20%.					
	<del></del>						~
	The physician order	dated, 7/6/17, documented,					
	opply alginotes & co	ock with NS (normal saline, ver with dry dressing QD					
	(every day) and PRI						
	(Ovory day) and i to	v (as needed).					·
	*Alginate is a bioma	terial that has found					
	numerous application	ns in biomedical science and	-				
	engineering due to i	ts favorable properties.					
	including biocompat	ibility and ease of gelation.		-			-
	Alginate hydrogels h	ave been particularly					
	attractive in wound i	nealing, drug delivery, and					*
	nels retain structural	pplications to date, as these similarity to the extracellular-	_				
	matrices in tissues a	and can be manipulated to	.5	-	•		
	play several critical r						
	The July 2017 TAR ( record) documented buttock with NS, app dressing QD and PR	Treatment administration in part, "Cleanse L & R oly alginate & cover with dry N." The July TAR did not treatments to the pressure					

areas prior to 7/6/17. A request was made to the administrative team, on 9/27/17 at approximately

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FURI MB NC	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY  OMPLETED
		495362	B. WING			09	C 9/29/2017
	NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION			906	REET ADDRESS, CITY, STATE, ZIP CODE 5 THOMPSON STREET		
AUNCAN	B RORORO ARB REI			AS	HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRF	IX5) COMPLETION DATE
F 314	Continued From pa	ge 160 ient #4's June 2017 TAR.	F	314			
	1.20 p.iii., for Nesic	ient #45 June 2017 TAIN.					
	last revised on 7/20 resident has the po of skin integrity r/t ( (as evidenced by) h "Interventions" doct treatments as order effectiveness. Associating weekly. Me where possible. As positioning PRN. For preventative treatment, attempt alternate methods to	ess/record/monitor wound easure length, width and depth esist resident with turning and ollow physician order for ent. If resident refuses to determine why and try o gain compliance. If resident					
	again. Inform the re any new area of ski changes in skin sta healing, s/sx (signs wound size and or s [frequently]) to ensu Report loose dressi	nterventions, wait and try esident/family/caregivers of in breakdown. Monitor tus; appearance, color, wound and symptoms) of infection stage. Monitor dressing (freq ure it is intact and adhering. ing to nurse. Notify nurse of				-	-
	blisters, bruises, dis or daily care. Notify condition. Weekly s comprehensive car documented in part skin integrity @ (at) to) impaired mobilit documented in part ordered and monito Assess/record. Mor	e plan dated, 7/6/17, , ""The resident has impaired bilateral buttocks r/t (related y." The "Interventions" , "Administer treatments as	- -				

assist resident with turning and positioning q (every) 2 hours and PRN. Braden scale quarterly. Monitor changes in skin status;

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			_		APPROVEO
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION	(X3) DAT	0938-0391 E SURVEY IPLETED
		495362	B. WING				C 29/2017
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION		906 T	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET ILAND, VA 23005	1 00,	23/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP OEFICIENCY)	DBE	(X5) COMPLETION DATE
	appearance, color, (signs/symptoms) of stage. Notify nurse breakdown; redness discoloration noted Therapy screen PR checks."  An interview was controlled practical nurse) #4, 9/27/17 at 3:05 p.m first made aware of buttocks, LPN #4 stadocumented the datasked if she had an records, LPN #4 stadocumented on their stated, "The one woundstageable, it was right buttock/ischium wound." When asked what saware of the wound ([Administrative staff wound doctor), and he agreed with my sput in place for the rhere a lot in July due When asked what we was to the real point of the wound when asked what we was the property of the real points and the property of the real points are property of the real points and the property of the real points and the property of the real points and the property of the real points and the property of the real points and the property of the real points and the property of the real points and the prope	wound healing, s/sx of infection, wound size and/or e of any new areas of skin is, blisters, bruises, during bath or daily care. RN (as needed). Weekly skin onducted with LPN (licensed the wound care nurse, on the wounds on Resident #4's tated, "I'm not sure but I by in the nurse's notes." When any pressure ulcer tracking ated that she did and went off N #4 returned at 3:10 p.m. records for Resident #4. scribe the resident's wounds arved on 7/6/17 and m in the record, LPN #4 bund, the left hip wound was dark and crusty looking. The m wound was a stage III and who staged the wounds, she had staged the wounds, she had staged the wounds. She had staged the wounds to him, staging and gave me orders to resident. He (ASM #3) wasn't e to illness and vacations." was in place prior to her being wounds on 7/6/17, LPN #4	F 3	14	OEFICIENCY)		
							ļ

On 9/28/17 at 8:15 a.m. ASM #2, the director of nursing/clinical services, informed this surveyor

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		: & MEDICAID SERVICES			0	MB NO	<u>. 0938</u> -0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	TAD (EX)	E SURVEY (PLETED
		495362	B. WING			1	C
NAME OF I	PROVIDER OR SUPPLIER		t <u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/	29/2017
40111.431	D MIDSING AND DE	HARM TATION			THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION			HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP OEFICIENCY)	BE	IX5) COMPLETION DATE
F 314	Continued From pa	ge 162	F:	314			
	that the June TAR f	or Resident #4 was not				•	
	available. ASM #2   have."	stated, "I have given you what	÷				
		was conducted with LPN #4 a.m. When asked what was in			·		
	place prior to the id	entification of the pressure					
		N #4 slated, "We had an air				•	
		ne has a cushion in his asked if there was any					
		prior to the physician orders of					
	7/6/17, LPN #4 stat	ed, "There was no treatment					
		aware of." LPN #4 further ty has barrier cream for all					
	incontinent resident					-	
		onducted with LPN #6, the unit					
		7 at 8:35 a.m. When asked					
		residents skin assessments, ey (Skin assessments) are	٠				
		by the nurse. All A bed					
		leted on day shift and all B					
		ompleted on the evening shift. ent in the skin sweep book. If				-	
		nursing assistant) see an		-			
		tify the nurse. The nurse and				-	a
		it right away. If it's serious, und doctor involved but a					
		t in place immediately." When		-			
	asked if there was a	any treatment in place prior to					
		#4, LPN #6 stated she's have et back to this surveyor.					-
	_	•					
		nducted with LPN #11 on					
		, regarding Resident #4's ated, "I found his wounds on					
		ame of the attending					
		e me an order for alginate and					

told me to contact (name of wound care doctor)

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	RM APPROVED 10. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	(X3) C	PATE SURVEY COMPLETED
		495362	B. WING_				C 09/29/2017
NAME OF F	PROVIDER OR SUPPLIER	<del></del>	<u>,                                     </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CO	! OE	09/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906 TI	HOMPSON STREET _AND, VA 23005		
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F 314	Continued From pa	ige 163	F 31	4	-		
	order and nurse's r	asked where the physician note for this was documented, a didn't know where any of that					
	director of nursing/ 9:11 a.m. ASM #2 v documentation that	onducted with ASM #2, the clinical services, on 9/28/17 at was asked to provide any tate treatment was in place prior ent #4's pressure wounds.					
	9/28/17 at approxing stated they could in any orders to correspressure area. Who assessment and treesidents get show look at the skin and skin sheet. The nuneeded. The nurse assessment. If ord doctor. If the area something, update wound doctor) invoiling to show y	onducted with ASM #2 on nately 10:30 a.m. ASM #2 ot find the June 2017 TAR or spond with treatment for the en asked the process for skin eatment, ASM #2 stated, "The ers twice a week. The CNAs if abnormal they note it on the rse is then to follow up if s's do a weekly skin ers are needed they call the is pressure the implement the TAR and get (Name of Ived. He comes on Mondays, ou something was done. The opliant with positioning, it's on					
	9/28/17 at 11:10 a.r process is for chec stated, "I check the bathing them, chan When asked if she before what does s the nurse." When a	onducted with CNA #4 on m. When asked what the king a resident's skin, CNA #4 m every time I am giving care; ging them or giving showers." finds anything different than he do, CNA #4 stated, "I tell isked if the nurses are sey tell them changing in the					

skin, CNA #4 stated, "Yes."

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICA	ARE & MEDICAID SERVICES				). 0938-0391
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) OA	TE SURVEY MPLETEO
	495362	B. WING		08	C 9/29/2017
ASHLAND NURSING AND			STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND, VA 23005		
PREFIX (EACH OEFICII	STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULO BE	IX5  COMPLETION OATE
F 314 Continued From	n page 164	F 314	ŀ		
ASM #2, the dir and ASM #4, th services, were r	lirector/administrator, ASM #1, ector of nursing/clinical services, e regional director of clinical made aware of the concern for				-

ASM #2, the director of nursing/clinical services, and ASM #4, the regional director of clinical services, were made aware of the concern for harm on 9/28/17 at 11:32 a.m. ASM #2 presented a form, "Guidelines for Unavoidable Wounds" dated, 8/26/16. ASM #2 stated, "He has the unavoidable form. Nothing has changed. He is always at risk for pressure ulcers. Nothing has changed in his condition or his comorbidities." ASM #4 stated, that the facility did have a plan of action in place dated in January and revised in March of 2017. When asked the AOC (allegation of compliance date) ASM #4 stated it was in March. ASM #4 was informed Resident #4's wounds were found in July 2017 after this date of alleged compliance.

An interview was conducted with ASM #3, the wourld care doctor on 9/28/17 at 12:00 p.m. When asked when he first saw Resident #4's wounds, ASM #3 stated, "I didn't see him until 7/24/17. I was out of town and out for unscheduled time off during the month of July." When asked to describe the wounds when he saw them, ASM #3 stated, "The one wound was black eschar when I first saw it and the second wound was a stage III wound. The resident is known to me. He had previously heel pressure wounds that we healed. He is a dependent young man who dislikes to offload pressure. He spends much of his day in the wheelchair. I have got him to go back to bed around 4:00 p.m. every day." When asked if the resident can lift himself up to relieve pressure, ASM #3 stated, "Yes, I believe he can but he doesn't do it that often. He's not offloading every 2 hours as I would like him to do so." When asked if therapy has been

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	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			ONSTRUCTION	(X3) O	O. 0936-0391 ATE SURVEY DMPLETEO
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NAME OF	PROVIOER OR SUPPLIER				EET AOORESS, CITY, STATE, ZIP COOE	<del></del> -	
ASHLAN	ND NURSING AND RE	HABILITATION			THOMPSON STREET ILAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF OEFICIENCIES  Y MUST BE PRECEOED BY FULL  SC IOENTIFYING INFORMATION)	IO PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	OBE	(X5) COMPLETION OATE
F 314	Continued From pa	age 165	F3	14			-
	involved in his pres #3 stated, "I do not	sure ulcers treatments, ASM know about that."		,			
	member (OSM) #10 9/28/17 at 2:15 p.m	onducted with other staff 0, the director of therapy, on 1. When asked if therapy was lent #4, OSM #10 stated	<del>-</del>		•		÷
	Resident #4 was cu training program. W working with him fo	urrently on caseload for bowel When asked if they were r bed mobility and transfers, would have to check.			•		
	asked if he the residuheelchair for press stated, "He's had the year when I came. last year. It's the hi on the market." Wh	at 9/28/17 at 2:38 p.m. When dent had a cushion in his sure reduction, OSM #10 se same cushion since last loid an audit when I arrived ghest level of cushion that is en asked if the slide board is			-		
	his pressure ulcers, the most appropriat #10 presented document provided document physical therapy cas 4/6/17. The resider case load from May arm strengthening, There was no document 2017, for the Restor therapy started work	re transfer technique in light of OSM #10 stated, "Yes, it's e transfers type for him." OSM amentation of when therapy dent. The documentation ed that Resident #4 was under seload from 3/8/17 through at was on restorative therapy 2017 through June 2017 for and Omni cycle for his legs: mentation provided for July rative program. Occupational king with Resident #4 on 7, after his pressure ulcers 7.	- -				
		m ASM #2 the director of					

nursing/clinical services presented to this surveyor a June 2017 TAR and a telephone physician order. The physician order was dated,

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AND PLAN OF CORRECTION    IDENTIFICATION NUMBER:   (X2) MULTIPLE CONSTRUCTION   (X3) OATE SURVE COMPLETED   A. BUILDING	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FC OMB	DRM APPROVED
ASHLAND NURSING AND REHABILITATION  ASHLAND NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314 Continued From page 166 (3/19/17 and documented, "Clean with NS (normal saline) apply bacitracin and cover with dry dressing," The June 2017 TAR documented every day except, 6/23/17, 6/26/17, 6/27/17 and 6/30/17. This physician order and treatment on the TAR did not document where to put this treatment. This treatment was not transferred to the July TAR.  The order of 6/19/17, presented as being put in place for Resident #4's pressure sores, was not documented as administered every day by staff. There were missing treatments as noted above. The July 2017 TAR failed to document any treatment for Resident #4's pressure ulcers until the wound care nurse implemented ireatment orders on 7/6/17. Per the documentation, Resident #4's wounds went untreated for six straight days. When the wound nurse was made aware of the wounds, they were assessed and documented as stage III and unstageable wounds.  The facility policy, "Clinical Guideline - Skin &						CONSTRUCTION		NO. 0938-0391 ) DATE SURVEY COMPLETED
ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 314 Continued From page 166 6/19/17 and documented, "Clean with NS (normal saline) apply bacitracin and cover with dry dressing." The June 2017 TAR documented every day except, 6/23/17, 6/26/17, 6/27/17 and 6/30/17. This physician order and treatment on the TAR did not document was not transferred to the July TAR.  The order of 6/19/17, presented as being put in place for Resident #4's pressure sores, was not documented as administered every day by staff. There were missing treatments as noted above. The July 2017 TAR falled to document any treatment for Resident #4's pressure ulcers until the wound care nurse implemented (reatment orders on 7/6/17, Per the documentation, Resident #4's wounds went untreated for six straight days. When the wound nurse was made aware of the wounds, they were assessed and documented as stage III and unstageable wounds.  The facility policy, "Clinical Guideline - Skin &			495362	B, WING				
ASHLAND NURSING AND REHABILITATION  (X4) 10 PREFIX TAG  SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 166 6/19/17 and documented, "Clean with NS (normal saline) apply bacitracin and cover with dry dressing." The June 2017 TAR documented in part, "Clean with Normal saline apply bacitracin and cover." The treatment was documented every day except, 6/23/17, 6/26/17, 6/27/17 and 6/30/17. This physician order and treatment on the TAR did not document where to put this treatment. This treatment was not transferred to the July TAR.  The order of 6/19/17, presented as being put in place for Resident #4's pressure sores, was not documented as administered every day by staff. There were missing treatments as noted above. The July 2017 TAR failed to document any treatment for Resident #4's pressure ulcers until the wound care nurse implemented treatment orders on 7/6/17. Per the documentation, Resident #4's wounds went untreated for six straight days. When the wound nurse was made aware of the wounds, they were assessed and documented as stage III and unstageable wounds.  The facility policy, "Clinical Guideline - Skin &	NAME OF F	PROVIOER OR SUPPLIER			STR	EET AOORESS, CITY, STATE, ZIP COOF	<u>'</u> _	03/23/2017
F314 Continued From page 166 6/19/17 and documented, "Clean with NS (normal saline) apply bacitracin and cover with dry dressing." The June 2017 TAR documented every day except, 6/23/17, 6/26/17, 6/27/17 and 6/30/17. This physician order and treatment on the TAR did not document where to put this treatment. This treatment was noted above. The July 2017 TAR failed to document any treatment for Resident #4's pressure ulcers until the wound care nurse implemented ireatment for document any reatment for Resident #4's wounds went untreated for six straight days. When the wounds, they were assessed and documented as stage III and unstageable wounds.  The facility policy, "Clinical Guideline - Skin &	ASHLAN	ID NURSING AND RE	HABILITATION					
6/19/17 and documented, "Clean with NS (normal saline) apply bacitracin and cover with dry dressing." The June 2017 TAR documented in part, "Clean with Normal saline apply bacitracin and cover." The treatment was documented every day except, 6/23/17, 6/26/17, 6/27/17 and 6/30/17. This physician order and treatment on the TAR did not document where to put this treatment. This treatment was not transferred to the July TAR.  The order of 6/19/17, presented as being put in place for Resident #4's pressure sores, was not documented as administered every day by staff. There were missing treatments as noted above. The July 2017 TAR failed to document any treatment for Resident #4's pressure ulcers until the wound care nurse implemented treatment orders on 7/6/17. Per the documentation, Resident #4's wounds went untreated for six straight days. When the wound nurse was made aware of the wounds, they were assessed and documented as stage III and unstageable wounds.  The facility policy, "Clinical Guideline - Skin &	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	Κ	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULOBE	(X5) COMPLETION E OATE
provide a system for identifying skin at risk, implementing interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Process: On admission/readmission the resident' skin will be evaluated for baseline skin condition and documentation in the medication record. Braden	F 314	6/19/17 and docum saline) apply bacitra dressing." The Junipart, "Clean with Na and cover." The treevery day except, 6 6/30/17. This physic the TAR did not documented as additional to the July TAR.  The order of 6/19/1 place for Resident adocumented as addithere were missing. The July 2017 TAR treatment for Resident adocumented as read the wound care nurorders on 7/6/17. President #4's wound straight days. When aware of the wound documented as stage wounds.  The facility policy, "Wound" documented as ystem for implementing intervand monitoring as in health, healing and of/prevention of preadmission/readmison/readmission/readmission/readmission/readmission/readmission/re	mented, "Clean with NS (normal acin and cover with dry e 2017 TAR documented in ormal saline apply bacitracin ratment was documented \$123/17, 6/26/17, 6/27/17 and cian order and treatment on cument where to put this atment was not transferred to 7, presented as being put in #4's pressure sores, was not ministered every day by staff. In treatments as noted above, failed to document any ent #4's pressure ulcers until se implemented treatment er the documentation, ands went untreated for six in the wound nurse was made als, they were assessed and ge III and unstageable  Clinical Guideline - Skin & and in part, "Overview: To redicated to promote skin decrease worsening ssure injury. Process: On sion the resident' skin will be ne skin condition and	F 3	14			

admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition. Licensed Nurse to complete skin

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOING COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH OEFICIENCY MUST BE PRECEOED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULO BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 314 Continued From page 167 F 314 evaluation weekly and prior to transfer/discharge and document in the medical record. CNA to complete skin observations and report changes. to Licensed Nurse. Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved. License Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record. Develop individualized goals and interventions and document on the care plan and the CNA Kardex. Refer to therapy as indicated. Monitor resident's response to treatment and modify treatment as indicated. Evaluate the effectiveness of interventions, and progress towards goals during the care management meting and as needed." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 522 (2) This information was obtained from the following website: http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-injury-stages/ (3) This information was obtained from the following website:

FORM CMS-2567(02-99) Previous Versions Obsolete

F 318 483.25(c)(2)(3) INCREASE/PREVENT

following website:

23967/

http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-injury-stages/ (4) This information was obtained from the

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC32

F 318

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		E& MEDICAID SERVICES			FORM APPROV
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		495362	B. WING		C 09/29/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET AOORESS, CITY, STATE, ZIP CO	DOE
ASHLAN	D NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COLUBIETU
F 318	Continued From pa	age 168	F 3	18	
	(c) Mobility.			1.Resident #12 has	his
	(C) WOOMity.			right hand splint ap	plied
		limited range of motion te treatment and services to		and left hand palm	
		notion and/or to prevent further		protector applied	as
	decrease in range	of motion.		per physician's orde	er.
	(3) A resident with I	limited mobility receives		Resident #12 currer	ntly
	appropriate service	s, equipment, and assistance		resides in the facilit	у
		ove mobility with the maximum ndence unless a reduction in		and has no s/s of	
	mobility is demonst	rably unavoidable.		adverse effects. LPi	N #10
		NT is not met as evidenced		has been counseled	lon
	by: Based on observa	tion, staff interview, facility		not following Physic	cian
	document review a	nd clinical record review, it		orders and educate	d on
		at facility staff failed to provide ices to maintain ROM (range		following physician	
	of motion) for one of	of 34 residents in the survey		orders LPN #10 has	
	sample, Resident#	<sup>£</sup> 12.		been counseled on	not
	The facility staff fail	ed to ensure Resident #12's		following Physician	
		d left hand palm protector was		orders and educate	d on
	in place per the plan of care and physician's order to prevent further contractures.			following physician	
	•			orders as indicated	
	The findings include	e:	-		
	Resident #12 was a	admitted to the facility on		2.A quality review o	of

8/12/15 with diagnoses that included but were not

limited to: enlarged prostate, heart failure, muscle

weakness, hypothyroidism, dementia, and COPD

Resident #12's most recent MDS (minimum data

impaired in cognitive function scoring 03 out of 15

set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17.

Resident #12 was coded as being severely

(chronic obstructive pulmonary disease).

current residents with

Physician orders for

hand splints/palms

protectors has been

based on findings.

performed. Follow up

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	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOII		ONSTRUCTION	(X3) OAT	re SURVEY MPLETEO
		495362	B. WING_				C /29/2017
NAME OF	PROVIOER OR SUPPLIER	-		STRE	ET AOORESS, CITY, STATE, ZIP COOE	1 00,	23/2017
ASHLAN	ID NURSING AND RE				THOMPSON STREET LAND, VA 23005		
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	exam. Resident #1 dependence on one locomotion on the it extensive assistant personal hygiene.  On 9/26/17 at 5:15 made of Resident # his hands at his sid appeared to be slig was under the cove was not wearing a p  On 9/27/17 at 7:38 made of Resident # his hands at his sid right hands appeare He was not wearing his bilateral hands.  On 9/27/17 at 10:05 made of Resident # his hands at his side right hands appeare He was not wearing his bilateral hands.  On 9/27/17 at 12:35 made of Resident # his hands at his side right hands appeare He was not wearing his bilateral hands.	Interview for Mental Status)  2 was coded as requiring total e staff member with dressing, unit, eating, and bathing; and ce from one staff member with  p.m., an observation was f12. He was lying in bed with e. The fingers to his left hand htly contracted. His right hand ars and was not visible. He calm protector to his left and ed to be slightly contracted. In a splint or palm protector to  a.m., an observation was f12. He was lying in bed with e. The fingers to his left and ed to be slightly contracted. In a splint or palm protector to  a.m., an observation was f12. He was lying in bed with e. The fingers to his left and ed to be slightly contracted. In a splint or palm protector to  a.m., an observation was f13. He was lying in bed with e. The fingers to his left hand and the contracted. His right hand and was not visible. He ealm protector to his left hand.	F3	18	3. Licensed Nurses reeducated by DCS/Designee regarding following Physician orders on application of hand splints and palm protectors. DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of application of hand splints and palm protectors x4 weeks, weekly x4weeks and then monthly, PRN and as indicated.	Ţ.	

made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILOING COMPLETEO С 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY F 318 Continued From page 170 F 318 was under the covers and was not visible. He was not wearing a palm protector to his left hand. On 9/28/17 at 10:30 a.m., an observation was made of Resident #12. He was not wearing his left hand palm guard or his right hand splint. Review of Resident #12's POS (physician order sheet) signed by the physician on 8/28/17. documented the following orders: "Right hand 4.DCS/Designee to splints on during the day, check skin once removed. Left hand palm protector on at all conduct quality times. May remove for hygiene, skin checks, monitoring regarding check placement every shift." physician notification Review of Resident #12's "Impaired skin integrity" with documentation in care plan dated 8/31/16, documented the the medical record as following interventions: "Left hand palm protector as ordered. Right hand splint as ordered." indicated. Findings to be These interventions were initiated on 2/2/17. communicated to the QAPI committee Resident #12's most recent "Nursing Tech Information Kardex" documented the following: monthly and as "Splint: R (right) hand/palm protectors." The indicated. Quality Kardex failed to mention Resident #12's palm protector to his left hand. monitoring schedules modified based on Review of Resident #12's September 2017 TAR (treatment administration record) revealed blanks findings (no signatures) under the following treatment: November 14, 2017 "Right hand splints on during the day check skin once removed."

Further review of the September 2017 TAR revealed initials or signatures on 9/26/17 for 3-11 shift and 9/27/17 for 7-3 and 3-11 shifts indicating

that the left hand splint was in place.

On 9/28/17 11:05 a.m., an interview was

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	PROVIOER OR SUPPLIER	HABILITATION	<del></del>	STREET AOORESS, CITY, STATE, ZIP C 906 THOMPSON STREET ASHLAND, VA 23005	)OOE	09/29/2017
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F 318	#10, Resident #12's Resident #12 was shis right hand and a hand, LPN #10 look and stated that he win place. When asked what i #10 stated that she when asked what i #10 stated that initial completed. When a (no signatures) for the Resident #12's Sep "That is supposed that is supposed that is supposed that is supposed that is supposed that in place on 9/2 probably should have when asked who wisplints, and palm protestated, "yes." When was in place on 9/2 probably should have when asked who wisplints, and palm protestated, and palm protestated that the sp was asked to review this surveyor. LPN: Resident #12's Kard would know to put a #12's left hand if it is Kardex, LPN #10 stated information in a LPN #10 accompanies.	N (licensed practical nurse) s nurse. When asked if supposed to have a splint to a palm protector to his left ked at his physician's orders was supposed to have splints ked if they were in place, LPN	F	318		
	On 9/28/17 at 11:33	a.m., an interview was (certified nursing assistant)				

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	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
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F <b>3</b> 18	Continued From pa	ge 172	F:	318	F328		
	#4, Resident #12's	CNA. When asked how	. ,	010	1.Resident #16		
		what to put into place for skin.			nebulizer and CPAP		
		es etc., CNA #4 stated that she im the nurses or other CNAs.	-		machine are stored in a		
	When asked if she	had a reference to use that			sanitary manner.		
•	documented reside there is, I don't kno	nt needs, CNA #4 stated, "If w where it is "			Resident #16 is		
	On 9/28/17 at 2:08 p.m., an interview was conducted with OSM (other staff member) #10,				currently using CPAP	-	
					machine as indicated by	-	
		py. When asked about the			Physician order.		
		r recommending a splint or			Resident #31's external		
		10 stated that therapy will start a trial with a resident to			filter on oxygen		
	see if they can toler	ate the splint and then ent with the splints after een educated on how to apply		•	concentrator has been		
					cleaned appropriately.	-	
		sked if a palm protector was a			Resident #14's external	;	
		#10 stated, "yes." When			filter on the oxygen		
		12 reeded splints in place to and, OSM #10 stated that he -			concentrator has been	e en en en en en en en en en en en en en	
	should be wearing s	and be really, com #10 stated that he all the stated the stated that he all the stated that			cleaned appropriately.		
	On 9/28/17 at 5:15	On 9/28/17 at 5:15 p.m., ASM (administrative			2.A quality review of		
	staff member) #1, tl	ne administrator/executive	- **		current residents with		
		2, the DON (Director of vices were made aware of the			Physician orders for	,	
	above concerns.		12.1		oxygen and CPAP		
	No further informati	on was presented prior to exit.			machine has been	·	
F 328 SS≈ <b>D</b>		)(h)(i)(j) TREATMENT/CARE	F:	328	performed.		
	(b)(2) Foot care. To ensure that residents receive				3.Licensed Nurses re-		
	proper treatment an	d care to maintain mobility			educated by		
	and good foot health, the facility must:				DCS/Designee regarding	ļ	
					following Physician		

#### DEPARTMENT OF HEALTH AND HUIVII IN SERVICES

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	PROVIDER OR SUPPLIER  D NURSING AND REI	- HABILITAT(ON		90	TREET ADDRESS, CITY, STATE, ZIP CODE 06 THOMPSON STREET SHLAND, VA 23005	1 031	29/2011
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F 328	with professional st to prevent complical medical condition(s medical condition(s).  (ii) If necessary, assappointments with a arranging for transpappointments.  (f) Colostomy, uretarnequire colostomy, uservices, receive suprofessional standar comprehensive persibe resident's goals.  (g)(5) A resident whreceives the appropriate compliance of the propriate compliance of the prevent compliance of the prevent compliance of the prevent compliance of the prevent compliance of the prevent consistent of the preven	e and treatment, in accordance andards of practice, including tions from the resident's ) and sist the resident in making a qualified person, and portation to and from such erostomy, or ileostomy care, sure that residents who preterostomy, or ileostomy inches care consistent with reds of practice, the son-centered care plan, and and preferences.  To is fed by enteral means triate treatment and services ications of enteral feeding ited to aspiration pneumonia, dehydration, metabolic masal-pharyngeal ulcers.  Parenteral fluids must be stent with professional e and in accordance with	F	328	orders on oxygen and CPAP machines and cleanliness and stort of Oxygen and CPAP equipment.  DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of Oxygen/CPAP Physicorders and cleanline and storage of oxygend CPAP equipment weeks, x4 weeks athen monthly, PRN as indicated.	rage of cian ess en  t x4 nd	
	and tracheal suction that a resident who	including tracheostomy care ing. The facility must ensure needs respiratory care, my care and tracheal					

suctioning, is provided such care, consistent with

professional standards of practice, the

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<u>CENTER</u>	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			C	MR NC	<u>0. 0938-0391</u>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET ILAND, VA 23005	1 09	9/29/2017	
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	residents' goals and this subpart.  (j) Prostheses. The resident who has a and assistance, constandards of practic person-centered cand preferences, to prosthetic device. This REQUIREMENT by:  Based on observate document review as was determined the maintain respiratory manner for three of sample, Residents to have a physician respiratory equipment the survey sample,  1.a. The facility staff nebulizer and CPAF pressure) machine  1. b. The facility staff order for Resident #  2. The facility staff the external filter on Reconcentrator that was	rson-centered care plan, the ad preferences, and 483.65 of the facility must ensure that a prosthesis is provided care insistent with professional ce, the comprehensive are plan, the residents' goals to wear and be able to use the NT is not met as evidenced tion, resident interview, facility and clinical record review, it at the facility staff failed to y equipment in a sanitary f 34 residents in the survey #16, #31 and #14; and failed in order for the use of ent for one of 34 residents in	F3	328	4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to b communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings 5. November 14, 2017			
	3. The facility staff fexternal filter on Res	failed to ensure a clean esident #14's oxygen						

concentrator that was being used to deliver

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE		CONSTRUCTION	(X3) D	O. 0938-0391 PATE SURVEY OMPLETED
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F 328	Continued From pa	ge 175	E 4	328		,	
		#14 when she was seated in	1	,20			_
	The findings include	e:					
	1.a. The facility staf nebulizer and CPAF manner.	ffailed to store Resident #16's machine in a sanitary					:- •
	7/13/17 with diagno limited to: stroke, m (chronic obstructive term for chronic nor is usually a combina chronic bronchitis (1 hypertrophy) (Benigicalled BPH-is a comprostate gland is enlighted Benign prostatic hypertrophy obstruction (2)), restriction pressure.	dmitted to the facility on ses that included but were not uscle spasms of back, COPD pulmonary disease) (general reversible lung disease that attion of emphysema and )), BPH (benign prostatic in prostatic hyperplasia-also dition in men in which the larged and not cancerous. Perplasia is also called benign by or benign prostatic less leg syndrome, and high				-	- - - -
·-	admission assessmereference date (ARD resident as being codecisions. Resident supervision to extensmember for all of his Section O - Special Programs, Resident a CPAP* or any resp						-
:	<ul> <li>* C-PAP, Continuous</li> <li>a machine used to as</li> </ul>	Positive Airway Pressure, is ssist people who are					

diagnosed with sleep apnea. A C-Pap machine

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NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	ST	REET AOORESS, CITY, STATE, ZIP CODE	_!0	9/29/2017
ACHIAN	ID NURSING AND RE	STADILITATIONS			6 THOMPSON STREET		
ASITEAN	ID NONSING AND RE	HADILITATION			SHLAND, VA 23005		
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F 328	Continued From pa	ge 176	F 3	28			
ļ		ure in the throat so that the		20			
	airway does not col	lapse when you breathe in. (3)					
	9/26/17 at 1:05 p.m mask and tubing was stand, not in a plast tubing was lying in the nightstand, not in a 4:28 p.m., the nebu CPAP tubing were it were at 1:05 p.m. Conebulizer mask and 9/27/17 at 9:28 a.m tubing and the CPAP	ade during the initial tour on . Resident #16's nebulizer as sitting on top of the night ic bag. Resident #16's CPAP the top drawer of the plastic bag. On 9/26/17 at lizer mask and tubing and in the same location as they observation was made of the tubing and CPAP tubing on . The nebulizer mask and P tubing were both in the top stand and both were					
	of the Resident #16 and the CPAP tubing drawer of the night suncovered. Resider When asked if he us CPAP machine, Resider the CPAP every night	o.m., observation was made is room. The nebulizer mask g were observed in the top stand and were both in t#16 entered the room, sed his nebulizer mask and sident #16 stated that he uses in and he has used the ran upper respiratory		-			
	documented in part, potential for an ineffe (related to) GERD (gdisease), COPD, hx dyspnea (difficulty brodocumented in part,	care plan dated, 7/26/17, "Focus: The resident has the ective breathing pattern r/t gastroesophageal reflux (history) of smoking and eathing)." The "Interventions" "Oxygen as ordered." plan, further documented in	- -				

part, "Focus: The resident has the potential for alteration in perfusion r/t (related/to) COPD,

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2017

STATEMENT OF CORRECTION  AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  A SULLONG  A SULLONG  NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  SUMMARY STATE MENT OF DEFIDENCIES PRETEX  FROM PERON RECORD STATE FRACEDED STATE  ASHLAND, VA 23005  FROM PERON RECORD STATE FRACEDED STATE  ASHLAND, VA 23005  FROM PRETEX  REGULATION TO ALSO INTERVING MERCHANON)  FROM INTERVINE MENT OF DEFIDENCIES TAG  FROM INTERVINE MENT OF DEFIDENCIES TAG  FROM PRETEX  REGULATION TO ALSO DETINEVEN MERCHANON)  FROM INTERVINE MENT OF DEFIDENCIES TAG  FROM PRETEX  REGULATION TO ALSO DETINEVEN MERCHANON)  FROM INTERVINE MENT OF DEFIDENCIES TAG  FROM PRETEX  REGULATION TO ALSO DETINEVEN MERCHANON)  FROM PRETEX  TO PRETEX  REGULATION TO ALSO DETINEVEN MERCHANON)  FROM PRETEX  TO PRETEX  REGULATION TO ALSO DETINEVEN MERCHANON  FROM PRETEX  TO PRETEX  REGULATION TO ALSO DETINEVEN MERCHANON  FROM PRETEX  TO PRETEX  TO PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  PRETEX  REGULATION TO COMPRETION  (EACH CORRECTION SHOULD BE CONTINUED BE CROSS-REFERENCED TO BE COMPRETION OF COMPRETION OF CONTINUED BE CROSS-REFERENCED TO BE COMPRETION OF COMPRETION  FROM THE ALBORITHM OF COMPRETION OF COMP	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION    SUMMARY STATEMENT OF DEFICIENCES   908 THOMPSON STREET	STATEMENT	FOF OFFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA			DNSTRUCTION	(X3) OATE SURVEY
ASHLAND NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEPLIENCES PREFIX TAG  SUMMARY STATEMENT OF DEPLIENCES PREFIX TAG  SUMMARY STATEMENT OF DEPLIENCES PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 328  Continued From page 177 arrhythmias, hypertension (high blood pressure)." The "Interventions" documented in part, "Monitor for SYS (signs and symptoms) of decreased cardiac output including changes in pulse, weakness, dizziness, shortness of breath, edema, lethargy, syncope. Notify physician of any change, in lung sounds or increasing edema. Vital signs as ordered and prn (as needed)."  An interview was conducted with LPN (ticensed practical nurse) #16 on 9/27/17 at 3:30 p.m. LPN #16 was asked how a resident's nebulizer should be stored after being used. LPN #16 stated, "It should be stored in a plastic bag with their name and date on it." When asked if the same applied to a CPAP mask, LPN #16 stated, "Steps when not in use." When asked why the respiratory equipment should be stored in plastic bags when not in use, LPN #16 stated, "It's for infection control purposes."  An interview was conducted with administrative staff member (ASM) #2, the director of nursing/clinical services, on 9/27/17 at 4:32 p.m. When asked how respiratory equipment, such as nebulizer masks and CPAP masks should be stored when not in use, ASM #2 stated, "They should be stored in a plastic bag and changed every seven days or as needed."  The facility policy, "Nebulizer" documented in part, "Disassemble device and rinse the mouthlece and hebulizer cup with water and air	NAME OF		495362	B. WING			
ASHLAND, VA 23005   CALIDATION   CALIDATION   CALIDATION   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PROPERTY   CALIDATION   PREFIX TAG   PROPERTY   CALIDATION   PREFIX TAG   PROPERTY   CALIDATION   PREFIX TAG   PROPERTY   CALIDATION   PREFIX TAG   PROPERTY   CALIDATION   CALIDATIO	I NAIME OF	PROVIDER OR SUPPLIER					00:20/2011
PREFIX REGULATORY ORLSC IORNTIFYING INFORMATION)  F 328 Continued From page 177     arrhythmias, hypertension (high blood pressure)."     The "interventions" documented in part, "Monitor for \$iS (signs and symptoms) of decreased cardiac output including changes in pulse, weakness, disziness, shortness of breath, edema, lethargy, syncope. Notify physician of any change, lin lung sounds or increasing edema: Vital signs as ordered and prn (as needed)."  An interview was conducted with LPN (licensed practical nurse) #16 on 9/27/17 at 3:30 p.m. LPN #16 was asked how a resident's nebulizer should be stored after being used. LPN #16 stated, "It's should be stored in a plastic bag when not in use," When asked why the respiratory equipment should be stored in plastic bags when not in use, LPN #16 stated, "It's for infection control purposes."  An interview was conducted with administrative staff member (ASM) #2, the director of nursing/clinical services, on 9/27/17 at 4:32 p.m. When asked how respiratory equipment, such as nebulizer masks and CPAP masks should be stored in a plastic bag and changed every seven days or as needed."  The facility policy, "Nebulizer" documented in part, "Disassemble device and rinse the mouthlpice and nebulizer cus with water and air	ASHLAN						
arrhythmias, hypertension (high blood pressure)."  The "Interventions" documented in part, "Monitor for S/S (signs and symptoms) of decreased cardiac output including changes in pulse, weakness, dizziness, shortness of breath, edema, lethargy, syncope, Notify physician of any change in lung sounds or increasing edema: Vital signs as ordered and prn (as needed)."  An interview was conducted with LPN (licensed practical nurse) #16 on 9/27/17 at 3:30 p.m. LPN #16 was asked how a resident's nebulizer should be stored after being used. LPN #16 stated, "It should be stored in a plastic bag with their name and date on it." When asked if the same applied to a CPAP mask, LPN #16 stated, "Yes, it's the same thing, in a plastic bag when not in use."  When asked why the respiratory equipment should be stored in plastic bags when not in use, LPN #16 stated, "It's for infection control purposes."  An interview was conducted with administrative staff member (ASIM) #2, the director of nursing/clinical services, on 9/27/17 at 4:32 p.m. When asked how respiratory equipment, such as nebulizer masks and CPAP masks should be stored in a plastic bag and changed every seven days or as needed."  The facility policy, "Nebulizer" documented in part, "Disassemble device and rinse the mouthpiece and nebulizer cup with water and air	PRÉFIX	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI	BE COMPLETION
dry. Place entire unit in a bag to be maintained in the resident's room."		arrhythmias, hyperta. The "Interventions" for S/S (signs and s cardiac output inclu weakness, dizzines: edema, lethargy, sy change in lung sour signs as ordered and An interview was copractical nurse) #16 #16 was asked how be stored after being should be stored in a and date on it." When a CPAP mask, LP same thing, in a plast When asked why the should be stored in plant LPN #16 stated, "It's purposes."  An interview was constaff member (ASM) nursing/clinical service When asked how respectively was a constaff member (ASM) nursing/clinical service when not in us should be stored in a every seven days or The facility policy, "N part, "Disassemble demouthpiece and nebudry. Place entire unit	ension (high blood pressure)." documented in part, "Monitor ymptoms) of decreased ding changes in pulse, s, shortness of breath, ncope. Notify physician of any nds or increasing edema. Vital d prn (as needed)."  Inducted with LPN (licensed on 9/27/17 at 3:30 p.m. LPN a resident's nebulizer should gused. LPN #16 stated, "It a plastic bag with their name on asked if the same applied on #16 stated, "Yes, it's the stic bag when not in use." It is respiratory equipment plastic bags when not in use, for infection control  Inducted with administrative #2, the director of ces, on 9/27/17 at 4:32 p.m. spiratory equipment, such as I CPAP masks should be se, ASM #2 stated, "They a plastic bag and changed as needed."  Ebulizer" documented in evice and rinse the ulizer cup with water and air	F 3.	28		

The facility policy, "General Administration of CPAP and BIPAP\*" did not document anything

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED С 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION מו (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG OATE DEFICIENCY) F 328 Continued From page 178 F 328 related to the storage of the equipment after use. \*Bi - PAP, bi-level Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. Bi Pap machine can be set for breathing in and breathing out pressure settings. (4) "The humidification system may be a source of bacteria. Pseudomonas aeruginosa is frequently the organism involved. Oxygen delivery equipment such as cannulas and masks can also harbor organisms." (Ignatavicius, D. & Workman, L. (2002) Medical Surgical Nursing, Critical Thinking for Collaborative Care, 4th edition. (p.492) Philadelphia, Pennsylvania: W. B. Saunders Company.) The executive director/administrator, (ASM #1). ASM #2, the director of nursing/clinical services and ASM #4 the regional director of clinical services, were made aware of the above findings on 9/27/17 at 5:23 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman: page 124. (2) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/urol ogic-diseases/prostate-problems/prostate-enlarge ment-benign-prostatic-hyperplasia.

(3) Also known as continuous positive airway pressure. CPAP is a treatment that uses mild air pressure to keep your breathing airways open. It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the

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1		& MEDICAID SERVICES			FOF A RMO	RM APPROVE[	
	T OF DEFICIENCIES OF CORRECTION			TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		495362	B. WING			C	
ASHLAN	ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COD 906 THOMPSON STREET ASHLAND, VA 23005	<u> </u>	09/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD RE	(X5) COMPLETION DATE	
F 328	mask, a tube that c machine 's motor, a the tube. CPAP is u breathing disorders information was obt website:	ge 179 connects the mask to the and a motor that blows air into sed to treat sleep-related including sleep apnea. This ained from the following	F3	28			

1. b. The facility staff failed to obtain a physician order for Resident #16's use of a CPAP machine.

www.webmd.com/sleep-disorders/sleep-apnea.

(4) This information was obtained from the

Observation was made during the initial tour on 9/26/17 at 1:05 p.m. Resident #16's CPAP tubing was lying in the top drawer of the nightstand, not in a plastic bag. On 9/26/17 at 4:28 p.m., the CPAP tubing was in the same location as it was at 1:05 p.m. Observation was made of Resident #16's CPAP tubing on 9/27/17 at 9:28 a.m. The CPAP tubing was in the top drawer of the night stand and was uncovered.

Review of the clinical record did not evidence any physician order for the CPAP machine and its use.

An interview was conducted with Resident #16 on 9/27/17 at 3:25 p.m. When asked if he uses his CPAP machine, Resident #16 acknowledged that he did indeed use it every night. When asked if he's used it since coming to the facility, Resident #16 stated he has used it for a long time now. He stated he had obtained it from the VA (veteran's administration). He stated he puts it on every

cs/cpap/

following website:

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILOING \_ COMPLETEO C495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID Ю PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE DEFICIENCY) F 328 Continued From page 180 F 328 night by himself. An interview was conducted with LPN #16 on 9/27/17 at 3:40 p.m. When asked if Resident #16 had any special equipment, LPN #16 stated, "He as a CPAP." When asked if a physician order is needed for the administration of a CPAP machine, LPN #16 stated, "Yes, Ma'am." The physician orders for Resident #16 were reviewed with LPN #16. No physician order was found related to the use of the CPAP machine. An interview was conducted with ASM #2, the director of nursing/clinical services, on 9/27/17 at 4:32 p.m. When asked if a physician order is required for the use of a CPAP by a resident. ASM #2 stated, "Yes." The facility policy, "General Administration of CPAP and BIPAP" documented in part, "Physician orders for CPAP/BIPAP therapy to include: Specific mode of therapy (CPAP or BIPAP). pressure settings, source gas (oxygen) if ordered. administrative device, duration of therapy and frequency, if not continuous." The executive director/administrator, (ASM #1),

ASM #2, the director of nursing/clinical services and ASM #4 the regional director of clinical services, were made aware of the above findings

on 9/27/17 at 5:23 p.m.

No further information was provided prior to exit.

2. The facility staff failed to ensure a clean external filter on Resident #31's oxygen concentrator that was being used to deliver oxygen to Resident #31 when he was seated in

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					TW APPROVED
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION	(X3) C	NO. 0938-0391 DATE SURVEY COMPLETED
		495362	B. WING				C
NAME OF F	PROVIOER OR SUPPLIER		<del></del>	STRE	ET AOORESS, CITY, STATE, ZIP COOE		09/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906	THOMPSON STREET		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCEO TO THE APPROPRIEM OF FICIENCY)	ULORE	(X5) COMPLETION OATE
F 328	Continued From pa	ge 181	FS	328			
	1/1/17 with a readmediagnoses that inclusions anxiety, depression difficulty with breath shortness of breath Resident #31's mosset), a 14-day asset (assessment refere Resident #31 as so on the BIMS (brief i indicating that Resident #36).	admitted to the facility on tission date of 6/9/17 with uded, but were not limited to: , asthma (a disease causing sing), kidney failure and .  It recent MDS (minimum data assment with an ARD note date) of 6/23/17, coded oring a 15 out of a possible 15 nterview for mental status) dent #31 was cognitively 1 was also coded as using					
	the facility was cond oxygen concentrato On inspection, the e back of the machine	eximately 1:00 p.m. a tour of flucted and Resident #31's r in his room was inspected. external filter attached to the exas observed with a thick ince attached to the filter.					
	concentrator was in:	o.m. Resident #31's oxygen spected and the filter on the in the same condition as on					
	staff member) #1, the director/administrate this surveyor into Re the oxygen concentre (other staff member)	a.m., ASM (administrative e executive or, was asked to accompany esident #31's room to look at ator. ASM #1 asked OSM of #3, the medical supplies serve the equipment. OSM					

#3 stated that he was responsible for the filters on the oxygen concentrators in the resident rooms.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
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		495362	B. WING		С
NAME OF	PROVIOER OR SUPPLIER		<del>'</del>	STREET AOORESS, CITY, STATE, ZIP (	09/29/2017
VEHIVI	ND NURSING AND RE	HADR ITATION		906 THOMPSON STREET	,OOE
AUTILA	NO NORSING AND RE	MADILITATION		ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG	PROVIDER'S PLAN OF CO	SHOULD BE SOURCE
F 328	Continued From pa		F3	28	
	ASM #1 and OSM a	#3 were asked to pull the filter			
	from the oxygen co	ncentrator in Resident #31's			
	room, OSM #3 pulle	ed the filter off and stated, "It			
	is filthy, and I just ca	ame iп here yesterday."			
	when asked if he h	ad changed the filter when he			
		9/27/17, OSM #3 stated that 3 was asked when he had last			
	changed the filter of	n Resident #31's oxygen			
	concentrator. OSM	#3 stated, "Last Tuesday."			
•	This writer confirme	ed that "last Tuesday" was			
	over seven days ag	o. When asked the purpose			
	of the external filter,	OSM #3 stated, "It is to stop			
	particles from enter	ing the machine." A policy			
	was requested at th				
		eaning of the oxygen			
	concentrators. OSN	#3 stated that the therapy			
	department maintair	ned the machines, out that he			
	was responsible for	the filters.			
	A review of the facili	ty document "Oxygen			
	Therapy" did not rev	real any documentation			
	relative to maintaining	ng the oxygen concentrator.			
	A review of the facility	ty document titled "Equipment			
	Maintenance Osvo	en Concentrator" revealed, in			
	part, the following dr	ocumentation; "(Name of			
	external maintenance	e company) will perform			
	maintenance on con	centrators according to			
	manufacturer's guide	elines and the frequency			
	specified in the site of	of service contract, but no			
	less than every six m	nonths." There is no further			

the oxygen concentrators.

documentation regarding changing the filters on

methodology to produce the oxygen gas output.

A review of the manufacturers guidelines revealed, in part, the following documentation; "The (trade name) concentrator uses a molecular

sieve and pressure swing absorption

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) OATE SURVEY COMPLETEO		
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NAME OF	PRO VIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	09/29/2017
ASHLAN	ID NURSING AND REI	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREFI TAG	(22 (21) COLVICEO IN EMELLION SHILL	HOBE COMPLETION
F 328	Ambient air enters to compressed. There on the back of the clean as needed. Emay require more ficleaning of the filter high dust, air polluta	the device, is filtered and then is one cabinet filter located cabinet. Remove the filter and Environmental conditions that requent inspection and include, but are not limited to: ants etc., Clean the cabinet cleaner or wash with a mild	F3	328	

No further information was provided prior to the end of the survey process.

the cabinet filter.

thoroughly. Thoroughly dry the filter and inspect for fraying, crumbling, tears and holes. Reinstall

3. The facility staff failed to ensure a clean external filter on Resident #14's oxygen concentrator that was being used to deliver oxygen to Resident #14 when she was seated in her room.

Resident #14 was admitted to the facility on 3/7/13 with a readmission date of 1/21/15 with diagnoses that included, but were not limited to: high blood pressure, asthma (a disease causing difficulty with breathing), chronic respiratory failure, diabetes and low red blood count.

Resident #14's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/24/17, coded Resident #14 as scoring a three out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #14 is severely cognitively impaired for daily decision making. Resident #14 was also coded as using

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING \_ COMPLETED С 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

F 328 Continued From page 184 oxygen.

F 328

On 9/26/17 at approximately 1:00 p.m., a tour of the facility was conducted and Resident #14's oxygen concentrator in her room was inspected. On inspection the external filter that is supposed to be attached to the back of the machine was observed missing.

On 9/27/17 at 4:00 p.m. Resident #14's oxygen concentrator was inspected and the filter continued to be missing from the back of the equipment.

On 9/28/17 at 10:25 a.m. ASM (administrative staff member) #1, the executive director/administrator, was asked to accompany this surveyor into Resident #14's room to look at the oxygen concentrator. ASM #1 asked OSM (other staff member) #3, the medical supplies director, to come observe the equipment. OSM #3 stated that he was responsible for the filters on the oxygen concentrators in the resident rooms. ASM #1 and OSM #3 were asked to pull the filter from the oxygen concentrator in Resident #14's room, OSM #3 looked behind the oxygen concentrator and stated there was no filter on the machine. When asked if there was supposed to be a filter present OSM #3 stated that a filter should be attached to the back of the oxygen concentrator. OSM #3 was asked when he had last checked the filter on Resident #14's oxygen concentrator, OSM #3 stated, "Last Tuesday." This writer confirmed that "last Tuesday" was over seven days ago. When asked the purpose of the external filter, OSM #3 stated, "It is to stop particles from entering the machine." A policy was requested at this time regarding maintenance and cleaning of the oxygen

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED
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1141/5 05		495362	B. WING		C 09/29/2017
ASHLAN (X4) IO	PROVIOER OR SUPPLIER  ID NURSING AND REI  SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND, VA 23005	
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO OEFICIENCY)	LOBE CONDUCTION
	department maintai was responsible for A review of the facil Therapy" did not review to maintaini A review of the facil Maintenance. Oxygpart, the following dexternal maintenance on commanufacturer's guid specified in the site less than every six redocumentation regathe oxygen concentred.	M #3 stated that the therapy ined the machines, but that he rathe filters.  It document "Oxygen veal any documentation ing the oxygen concentrator.  It document titled "Equipment gen Concentrator" revealed, in ocumentation; "(Name of ce company) will perform neentrators according to lelines and the frequency of service contract, but no months." There is no further arding changing the filters on rators.	F3	28	-
	A review of the man revealed, in part, the	ufacturers guidelines e following documentation;			

"The (trade name) concentrator uses a molecular sieve and pressure swing absorption methodology to produce the oxygen gas output. Ambient air enters the device, is filtered and then compressed. There is one cabinet filter located on the back of the cabinet. Remove the filter and clean as needed: Environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to: high dust, air pollutants etc., Clean the cabinet filter with a vacuum cleaner or wash with a mild liquid dish detergent and water. Rinse thoroughly. Thoroughly dry the filter and inspect for fraying, crumbling, tears and holes. Reinstall the cabinet filter.

No further information was provided prior to the end of the survey process.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY PLETEO
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ASTILAN	D NURSING AND RE	TABILITATION			LAND, VA 23005		
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F 329 SS= <b>D</b>	483.45(d)(e)(1)-(2) FROM UNNECESS	DRUG REGIMEN IS FREE SARY DRUGS	F	32 <b>9</b>			
	Each resident's dru	sary Drugs-General. g regimen must be free from . An unnecessary drug is any					
	(1) In excessive dos therapy); or	se (including duplicate drug		·	F329		
	(2) For excessive de	uration; or			1.Resident#32's	-	
	(3) Without adequa	le monitoring; or			antianxiety medication is being admitted as per	٠	
	(4) Without adequate	te indications for its use; or			Physician order.		
	(5) in the presence	of adverse consequences			Resident#32 suffered no		
	which indicate the d	ose should be reduced or		:	adverse s/s and did not		
	discontinued; or	oco enodia po foccoca of					
	d. 000 (111000)				require being transfer to		
	(6) Any combination	is of the reasons stated in			a higher level of care		ĺ
		rough (5) of this section.			secondary to extra dose		
	483.45(e) Psychotro Based on a compre resident, the facility	hensive assessment of a			-		-
	drugs are not given medication is neces	ave not used psychotropic these drugs unless the sary to treat a specific sed and documented in the				÷	
	gradual dose reduct	se psychotropic drugs receive ions, and behavioral sclinically contraindicated, in					

an effort to discontinue these drugs;

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				)RM APPROVED NO. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
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	ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP COR 906 THOMPSON STREET ASHLAND, VA 23005	DE	
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F 329	by: Based on staff inte and clinical record r	ge 187 NT is not met as evidenced rview, facility document review eview, it was determined that at to ensure residents the drug	F3	29		

regimen for three of 34 residents in the survey sample (Resident #32, #1 and #12) were free from unnecessary medications. 1. The facility staff failed to administer antianxiety

- medication to Resident #32 per physician's order. The facility staff administered an extra dose of Xanax to the resident on 7/17/17.
- 2. The facility staff failed to monitor Resident #1's behaviors for the use of the antipsychotic medication, Seroquel from May 2017 through September 2017.
- The facility staff failed to attempt non-pharmacological interventions prior to the administration of Ativan [1] to Resident #12 on 7/5/17, 7/15/17 and 7/28/17; and failed to document behaviors that required Ativan to be administered on 7/15/17 and 7/28/17.

### The findings include:

1. The facility staff failed to administer antianxiety medication to Resident #32 per physician's order. The facility staff administered an extra dose of Xanax (1) to the resident on 7/17/17.

Resident #32 was admitted to the facility on 5/26/17. Resident #32's diagnoses included but were not limited to: anxiety disorder, disease of the spinal cord and osteomyelitis (2). Resident #32's most recent MDS (minimum data set), a

of Xanax. Physician notification is documented. Resident#1 is currently being monitored daily for behaviors. A behavior sheet has been added to Resident#1's medication record. The facility has added nonpharmacological intervention has been added to Resident#12's profile.

2.A quality review of current residents with Physician orders for Antipsychotic medications has been performed.

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		E & MEDICAID SERVICES			FORM APPROVE
1	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T (X3) MI II .	TIPLE CONSTRUCTION	OMB NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER		<del>'  </del>	STREET ADORESS, CITY, STATE, ZIP C	<u>  09/29/2017</u>
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET	SDE
				ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COURTERNAL
F 329	Continued From pa	aga 188	Ε.		
1 020		ent with an ARD (assessment	F 3:	529	
	reference date) of !	9/12/17, coded the resident as		3.Licensed Nurses re	·-
	being cognitively in			educated by	
	Poviou of Residen	nt #32's clinical record revealed		DCS/Designee regard	4:
		dated 5/26/17 for Xanax 0.5			gnik
	milligrams by moutl	th every six hours. The		following Physician	
		heduled on Resident #32's July		orders on Antipsych	otic
I		ation administration record) to a.m. 6:00 a.m., 12:00 p.m., and		medication use.	
	6:00 p.m.	and oloo dama, reloo pana, end		Licensed Nurses re-	
	D	- 1001- V-		educated by	
}		t #32's Xanax controlled on record (a record of		DCS/Designee on	
<u> </u>	documentation that	t accounts for each pill) for July		Consulate policy on	
	2017 revealed the r	resident was administered		behavior flow sheet	and
		at 12:00 a.m., 6:00 a.m., 10:00 decided at 12:00 p.m. Further review of		non-pharmacologica	al
		ical record failed to reveal		interventions.	
		t the physician ordered an		DCS/Designee durin	.p
	extra dose of Xanax	x on this date.		Morning Clinical	Ь
		prehensive care plan initiated		Meeting to conduct	
		ented, "Psychoactive		quality monitoring o	
		ti-anxiety medication used for epression and uses and (sic)			ו <b>ן</b> איי איי איי איי איי איי איי איי איי איי
		edicationInterventions:		Antipsychotic	
	Medication as order	red (see MAR [medication		medication use,	
	administration recor	ːd])"		behavior monitoring	ğ
	On 9/29/17 at 8:58 a	a.m., an interview was		sheets and non-	
	conducted with LPN	N (licensed practical nurse)		pharmacological	
		what should be done			
		an's order on the MAR, LPN the order." When asked if			
	medications should	be given as ordered, LPN			*
		PN #10 was shown the			

physician's order for Resident #32's Xanax and shown the doses of the medication signed off on

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			01	FORM	APPROVED
STATEMENT	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1		V = 00 V 0 T - V - V	(X3) OAT	. 0938-0391 TE SURVEY MPLETEO
		495362	B. WING				C /29/2017
	PROVIOER OR SUPPLIER  ND NURSING AND RE			9	STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND, VA 23005		23/2011
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	IO PREFIX TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPR OEFICIENCY)	BF	(X5  COMPLETION DATE
	7/17/17. When ask administered an ex stated, "Yeah. It loo On 9/29/17 at 9:45 member) #1 (the ex and ASM #2 (the diservices) were made concern.  The facility/pharmace Preparation and Medocumented, "4. Primedication, Facility required by Facility including but not limedication is admirmedication, at the correct No further information was obtained information was obtained to the correct (1) Xanax is used to information was obtained to the correct (2) Osteomyelitis is information was obtained to the correct (2) The facility staff facility staf	ication utilization record on ked if Resident #32 was stra dose of Xanax, LPN #10 oks like it."  a.m. ASM (administrative staff xecutive director)/administrator irector of nursing/clinical de aware of the above  cy policy titled, "General Dose edication Administration" iror to administration of staff should take all rneasures policy and Applicable Law, nited to the following: 4.1: 4.1.1 Verify each time a nistered that it is the correct correct dose, at the correct trate, at the correct time"	F 32	29	medication x4 weeks, weekly x 4 weeks and then monthly, PRN and as indicated.  4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings.  5. November 14, 2017		
		e of the antipsycholic el from May 2017 through					1

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CENTERS	FOR MEDICARE	& MEDICAID SERVICES			•	FO	RM APPROVED
STATEMENT OF ANO PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
NAME OF BRO	More on allegate	495362	B. WING				C 09/29/2017
	VIDER OR SUPPLIER	HAB)LITATION		90	TREET AOORESS, CITY, STATE, ZIP CODE 06 THOMPSON STREET SHLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPI OEFICIENCY)	JIII O BE	(X5] COMPLETION OATE
Ref 3// we bli (mas da sk im ha ou per Ref ph 12 ag Al the #1 from ref con in a sk im of Ref on in a sk im a s	28/16. Resident ere not limited to: indness. Resider inimum data set; sessment with a set; sessment with a set; sessment with a set; sessment with a set; sessment with a set; sessment with a set; sessment with a section! Section! Section! Section! Section! Section! Section of the last several and section of the last several and section of the section of the wheelchair cord documented pulsive behavior section of the whom the wheelchair cord documented pulsive behavior section of the month of the section of the month of the section of the section of the use of the section of the	dmitted to the facility on #1's diagnoses included but repeated falls, dementia and at #1's most recent MDS ), a significant change in status ARD (assessment reference ded the resident's cognitive ion making as severely N coded Resident #1 as tipsychotic medication seven and ays during the look back #1's clinical record revealed a ated 4/4/17 for Seroquel (1) mouth twice daily for	F3	329			

evidenced by) self care deficit, Plays (sic) with feces, difficult to re-direct, attempts to stand

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		& MEDICAID SERVICES	т —		OMB N	O. 0938-0391	
	OF DEFICIENCIES F CORRECTION			JLTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED	
		495362	B. WING	G	,	C 09/29/2017	
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP 906 THOMPSON STREET ASHLAND, VA 23005	COOE	13/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTIO	N SHOULO BE E APPROPRIATE	IX5) COMPLETION OATE	
F 329	Refuses meds.(me Medication Antipsyd (diagnosis) of (Psyd (agitation)Interver behavioral sympton On 9/27/17 at 4:43 conducted with LPN #14 regarding the famonitoring for resid medication. LPN # behaviors should have the front of their MA record). LPN #14 swill document the tynon-pharmacological	(sic) staff assistance. dications)Psychoactive chotic medication in use for Dx chosis) Behaviors of ntions: Antipsychotic-Monitorns"  p.m. an interview was I (licensed practical nurse) acility process for behavior ents receiving antipsychotic 14 stated residents who have ave a behavior flowsheet in IR (medication administration tated the top of the flowsheet upe of behaviors, triggers,		329			
	document the type intervention provide behaviors. LPN #14 be done each time is behaviors. When a monitoring, LPN #14 antipsychotic (medic (psychiatric) doctor if the medication is or if it is controlling leading to the intervention of the medication is the medication is the medication is the medication is the medication is the medication is the medication is the medication is the medication in the medication is the medication in the medication is the medication in the medication in the medication is the medication in the medication in the medication is the medication in the medication in the medication is the medication in the medication in the medication is the medication in the medication in the medication in the medication is the medication in the medication in the medication in the medication is the medication in the medicat	cation), that will let the psych or MD (medical doctor) know working or if it needs adjusting behaviors."  o.m. ASM (administrative staff					
	director/administrate nursing/clinical serv regional director of a ware of the above according to the cor	or), ASM #2 (the director of ices) and ASM #3 (the clinical services) were made concern. ASM #2 stated inpany policy, not all residents residents with behaviors					

should have behavior flowsheets for nurses to

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ANO PLAN OF CORRECTION (X3) OATE SURVEY IDENTIFICATION NUMBER: A. BUILOING \_\_\_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPS ON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) F 329 Continued From page 192 F 329 document when behaviors occur. The facility policy titled, "Psychoactive Medications" documented, "Residents receiving psychoactive medication should have behaviors monitored every shift..." No further information was presented prior to exit. (1) "Quetiapine (also known as Seroquel) tablets and exterioed-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone orwith other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition. quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called

atypical antipsychotics. It works by changing the activity of certain natural substances in the brain."

non-pharmacological interventions prior to the administration of Ativan [1] to Resident #12 on

3. The facility staff failed to attempt

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT(VE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 193 F 329 7/5/17, 7/15/17 and 7/28/17; and failed to document behaviors that required Ativan to be administered on 7/15/17 and 7/28/17. Review of Resident #12's clinical record revealed that he was admitted under hospice services on 3/29/17 and the following order was written: "Ativan 2 MG (milligrams)/ML (milliliter) give 0.25 mg q (every) 4 hours prn (as needed) anxiety." Review of Resident #12's "Psychoactive medication Use" care plan dated 9/08/16, documented the following intervention: "Anti-Anxiety-Non-drug interventions." This intervention was initiated on 4/4/17. Review of Resident #12's July 2017 MAR (medication administration record) revealed that Resident #12 received Ativan 0.25 mg on 7/5/17. 7/15/17, and 7/28/17. There was no evidence in the clinical record that non-pharmacological interventions were attempted prior to the administration of Ativan. Further review of the MAR dated 7/2017, documented the following under "Nurse's. Medication Notes: "Date: 7/5. Drug/Strength Dose: Ativan 0.25. Reason: aggitated (sic)." Behaviors that required Ativan to be administered on 7/15/17 and 7/28/17 could not be found on the July 2017 MAR or in the July 2017 nursing notes. On 9/28/17 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse)

#10, Resident #12's nurse. When asked the process prior to administering a prn (as needed) anti-anxiety medication, LPN #10 stated that she would observe the resident and their behaviors, try to calm them down by redirection and

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		& MEDICAID SERVICES	<del>,</del>	·	(	OMB NO	) <u>. 0938-03</u> 91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495362	B. WING	·			С
NAME OF	PROVIDER DR SUPPLIER	1	12: 11:10		DEET ADDRESS OF THE PROPERTY O	_ 09	/29/2017
					REET ADDRESS, CITY, STATE, ZIP CODE		
ASHLAN	ID NURSING AND REI	HABILITATION		1	THOMPSON STREET		
(74) ID	SUMMARYSTA	TEMENT OF DEFICIENCIES		ASI	HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CDRRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	DRE	JX5J COMPLETION DATE
F 329	Continued From pa	ge 194	F:	329			
		dministering medication. LPN	, ,	125			
	#10 stated that if no	on-pharmacological					
	interventions are in						
		anti-anxiety medication. When					
	asked if she would	al interventions, LPN #10					
	stated that she wou						
	non-pharmacologic	al interventions attempted are					
	documented, LPN #						
		al interventions should be					
		ehavior sheet or nursing note. he would know if a nurse					
		macological interventions					
	prior to administerin						
	documented, LPN #	f10 stated, "You wouldn't."					
		dent #12's care plan was					
		macological interventions					
	Mere not attempted Ativan, LPN #10 sta	prior to administering prn					
		al (interventions) were not					
	attempted then the	care plan was not followed.					
	A July 2017 hehavio	r sheet for Resident #12					
	could not be found in						}
		o.m, ASM (administrative					-
	staff member) #1, th						
	director/administrato	or, and ASM #2, the DON					
	aware of the above i	/clinical services, were made		-			
	G. GIC OF THE GOOVE	mango.					
	Facility policy titled, '	"Psychotropic Medication					
	Use" did not address	s the above concerns.					
	No further information	on was presented prior to exit.					
		eat anxiety disorders. This					
	Information was obta Institutes of Health.	ained from The National					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF OEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRU	JCTION		NO. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				(X3	B) DATE SURVEY COMPLETED
		495362	B. WING			<del></del>	İ	С
NAME OF	PROVIOER OR SUPPLIER	433302	D. WING					09/29/2017
	ND NURSING AND REI	HABILITATION		906 T	HOMPS	RESS, CITY, STATE, ZIP CODE SON STREET		
(X4) ID	SLIMMADY STA	TEMENT OF DEFICIENCIES	<u>_</u> <u>l</u>	ASH		VA 23005		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EA	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPR DEFICIENCY)	ILD DE	(X5) COMPLETION E DATE
F 329	Continued From page	an 10E	_		F 37	1	<del></del> -	
. 020		<del>-</del>	F 3	29	1	. The cookware has b	100n	
	T0010988/?report=	n.nih.gov/pubmedhealth/PMH details.				washed and stored		
	483.60(i)(1)-(3) FO	DD PROCURE,	F 3	71		sanitary manner.	ııı a	
SS≍D	STORE/PREPARE/	SERVE - SANITARY			2.		and	!
	(i)(1) - Procure food	from sources approved or				or designee	has	
	considered satisfact	ory by federal, state or local				reviewed the kito		
	authorities.	•	•			with emphasis		
•	(i) This may include	food items obtained directly				cookware for kitc	on	
	from local producers and local laws or reg	s, subject to applicable State				maintained in a sani		
	allo local laws of Tec	julations. 				condition.	tary	
		es not prohibit or prevent			3.	_		
		produce grown in facility compliance with applicable			٠.			
	safe growing and for	od-handling practices.	-			STIG. [U	re-	
						educate dietary staff		
	(III) I his provision do	pes not preclude residents ds not procured by the facility.				properly washing a		}
		as not produced by the facility.		-		storing cookware in	n a	!
	(i)(2) - Store, prepare	e, distribute and serve food in					and	•
	service safety.	fessional standards for food				maintaining the kitch		
	•					in a sanitary condit		
	(i)(3) Have a policy r	egarding use and storage of				to ensure complianc	e is	
		dents by family and other e and sanitary storage,					and	
	handling, and consu	mption.			_	maintained.		
	this REQUIREMENT by:	T is not met as evidenced			4.	The Administrator a		
		on, staff interview and facility				or designee to cond	uct	
	document review, it v	vas determined that the				quality monitoring	of	ļ :
	a sanitary manner.	wash and store cookware in				the cookware be	ing	
	•					washed and stored in	ı a	
-	The facility staff failed	to allow cookware to air				sanitary manner a	nd	-
	ury, and stacked mur	tiple wet pans on top of each		,		kitchen bei	ing	
DRM CMS-256	67(02-99) Previous Versions O	bsolete EvenI ID: JHU711		acility ID	VAIRE	maintained in a sanita		
			,	, ,,		II Initoana	ıı Sılıcet	. Page 196 of 238

DEPAR	TMENT OF HEALTH	AND HUWAN SERVICES			PF	RINTED: 10/12/201
CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES		•		FORM APPROVE
STATEMEN	NT OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILOI	TIPLE CONSTRUCTION	1	MB NO. 0938-039 (X3) OATE SURVEY COMPLETEO
		495362	B. WING			С
NAME OF	PROVIOER OR SUPPLIER	,		STREET AOORESS, CIT	TV STATE ZID COOF	09/29/2017
ASHLAN	ND NURSING AND REI			906 THOMPSON STR ASHLAND, VA 230	REET	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER X (EACH CORRI CROSS-REFERI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULO E RENCEO TO THE APPROPRI OEFICIENCY)	DE COUDING
F 3 <b>7</b> 1	Continued From pa other (wet nested).		F 37	71		
	The findings include	e:		mon	dition. Quality	e
	During the initial tour of the kitchen on 9/26/17 at 1:02 p.m. with OSM (other staff member) # 4, the director of dietary, observation of the kitchen was made.			per v ensu	ducted 3X a week week for 4 weeks to	o d
	A storage rack that of was observed. Eight stacked on top of earns were examined	contained multiple sheet pans ht of the sheet pans were ach other. When the sheet ed they were found to be wet ed. This observation was 4.		week there Moni	o 1X a week for 4 ks then quarterly eafter. Quality hitoring schedule to modified based on ngs of quality	y y o n
	Dishes, Flatware, Ut pots, dishes, flatware	ity policy "Storage of Pots, Itensils" documented, "Air dry re, and utensils before a self-draining position."		the to be	ews. The results of quality monitoring e reviewed at the	f B
	ASM (administrative executive director/ac director of nurses/cli	on 9/27/17 at 5:50 p.m. with e staff member) # 1, the dministrator, ASM # 2, the linical services, and ASM # 4, r of clinical services, this red.		Impro meeti analy:	rance Performance ovement (QAPI) tings for review, vsis and further	) ,
	During an interview of ASM # 1 and ASM # shared.	on 9/28/17 at 4:50 p.m. with ¢2 this concern was again			mmendations. mber 14, 2017	
	of the survey.	on was provided by the end				
	483.45(b)(2)(3)(g)(h)	) DRUG RECORDS, IGS & BIOLOGICALS	F 431	1		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				TUT Sadan	KM APPROVE(	
STATEMEN	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495362	B. WING	à			С	
NAME OF	PROVIDER OR SUPPLIER		1		STREET AOORESS, CITY, STATE, ZIP COOE	0	9/29/2017	
ASHLAN	ND NURSING AND REI	HABILITATION		9	306 THOMPSON STREET ASHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	ix	PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	D B C	(X5) COMPLETION DATE	
F 431	drugs and biological them under an agre §483.70(g) of this punlicensed personn law permits, but only supervision of a lice (a) Procedures. A financeutical send that assure the accuracy dispensing, and administration of the consultation of the con	ovide routine and emergency als to its residents, or obtain the ement described in art. The facility may permit el to administer drugs if State y under the general ensed nurse.	F 4	431	1.The facility has discarded the expired Vancomycin intravenous bags from the medication room on Unit#2. The facility has discarded the expired eight ounce bottle of magic mouthwash from the medication room of Unit#2. The facility has discarded Two vials of			
	(2) Establishes a systematic disposition of all condetail to enable an a (3) Determines that that an account of all maintained and period (g) Labeling of Drugs and biological labeled in accordance professional principle appropriate accesso	s and Biologicals s used in the facility must be se with currently accepted es, and include the			Tuberculin solution, Humulin pen, Six vials o Copaxin, Novo log pen, Twelve Promethazine suppositories, eleven Marinol capsules, One vial of Lorazepam, ,Cathfloactivase, Three biscodyl suppositories, one bottle of Atropine and five Acetaminophen			
	<ul><li>(h) Storage of Drugs</li><li>(1) In accordance with the facility must store</li></ul>	and Biologicals. h State and Federal laws, all drugs and biologicals in s under proper temperature			suppositories. All medications have been reordered as per Physician order. The			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0301

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 <sup>4</sup> (X3) OATE SURVEY COMPLETED
		495362	B. WING		C 09/29/2017
NAME OF	PROVIOER OR SUPPLIER	· · ·		STREET AOORESS, CITY, STATE, ZIP	COOE 1 09/29/2017
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CO	ON SHOULO BE COMPLETION IE APPROPRIATE DATE
F 431	Continued From pa controls, and permi have access to the	t only authorized personnel to	F 4	31	
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distriquantity stored is more be readily detected.	t provide separately locked, discompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the sinimal and a missing dose can out to the interest of the storage of the providence		refrigera maintain tempera degrees.	iture of the itor on Unit#1 is ned at a ture of 38 All medication he facility are
	Based on observation, staff interview and fact policy review, it was determined that the facilit staff failed to label and store medications safe two of 2 medication rooms and one of 9 medication carts.			medicatio each unit	ty review of on rooms on has been
	medications. In the two Vancomycin (1) on 9/21/7 and one fi mouthwash (2) that	f failed to discard expired medication room on unit two, intravenous bags that expired ull eight-ounce bottle of magic was labelled as expired on yed available for use.		review of refrigerat temperat	or
		ailed to maintain the stor temperature between 36 grees on unit one.			formed. A view of each in cart has

The findings include:

c. The facility staff failed to lock one of nine

1.a. The facility staff failed to discard expired medications. In the medication room on unit two,

medication carts in the facility.

been performed.

PRINTED: 10/12/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
		495362	B. WING	<u>.                                    </u>	С
NAME OF	PROVIOER OR SUPPLIER		<u> </u>	STREET AOORESS, CITY, STATE, ZIP COOE	09/29/2017
ACUI AN	D MURCINO AND RE	IADII ITATION		906 THOMPSON STREET	
ASHLAN	D NURSING AND REI	HABILITATION		ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD	TRE COMPLETION
F 431	our nada i rom pa		F4	<del></del>	
	two Vancomycin (1) intravenous bags that expired on 9/21/7 and one full eight-ounce bottle of magic			3.Licensed Nurses re-	
	mouthwash (2) that was labelled as expired on			educated by	
	8/19/17 were observed available for use.			DCS/Designee regardi	ng
	A tour of unit two's medication room was			medication storage,	_
	conducted on 9/28/	17 with LPN (licensed		maintaining refrigerat	· .
	practical nurse) #10	In the medication room		temperature and	-1
	bags of Vancomycir	o 100 cc (cubic centimeter)  n. The expiration date was	_	keeping medication	
ļ	noted as 9/21/17. A	full eight-ounce bottle of		carts secured.	
	magic mouthwash v	vas also in the refrigerator			
	with an expiration day	ate of 8/19/17. When asked. edication rooms for expired		DCS/Designee to	~
	medications, LPN #	10 stated, "The night shift		conduct quality	
	checks the refrigera	tor. I would think they'd		monitoring of and	٠.
		eds (medications)." LPN #10 ations from the refrigerator.		storage of medication	<b>,</b>
	removed the medica	ations not the reingerator.		Refrigerator	=
		n. ASM (administrative staff		temperature logs and	
	member), the admir	nistrator/executive director,		Secure medication car	ts
	services, were made	ector of nursing/clinical e aware of the findings.		x4 weeks, weekly x4	·
				weeks and then	
	Review of the facility	s policy title, "Storage and		ma - the DDM	

monthly, PRN and as

indicated.

Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "4. Facility

should ensure that medications and biologicals that: (1) have an expired date on the label; (2)

been contaminated or deteriorated, are stored

separate from other medications until destroyed or returned to the pharmacy or supplier."

No further information was obtained prior to exit.

have been retained longer than recommended by manufacturer or supplier guideline; or (3) have

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				/ APPROVED ). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DA	7. 0936-039 TE SURVEY MPLETED
NAME OF	PPOVIDED OF SLIDBLIED	495362	B. WING	REET ADDRESS. CITY, STATE, ZIP CODE	09	C <u>/</u> 29/2017
ASHLAND NURSING AND REHABILITATION			90 A			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC  EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DIII D BE	(X5) COMPLETION OATE
F 431	b. The facility staff f	ge 200 alled to maintain the ator temperature between 36	F 431			

degrees and 46 degrees on unit one.

A tour of unit one's medication room was conducted on 9/28/17 at 12:20 p.m. with LPN #3. The refrigerator temperature was 48 degrees. When asked what the refrigerator temperature should be, LPN #3 stated, "36 to 46 degrees." When asked why they kept the refrigerator at that temperature, LPN #3 stated it was to store the medications. When asked what process staff followed if the refrigerator temperature was too high, LPN #3 stated, "We would turn up the temp [temperature] in the refrigerator." LPN #3 then adjusted the temperature in the refrigerator. At 12:45 p.m. LPN #3 checked the temperature with this surveyor and stated, "It's 58 degrees. I must have turned it the wrong way." LPN #3 readjusted the refrigerator temperature. Review of the September 2017 refrigerator temperature log recorded the temperature as being 40 degrees every day that month.

The medications in the refrigerator at the time were:

Two vials of Tuberculin purified protein (3). Instructions on the box was to store the medication between 36 and 46 degrees.

One Humulin (4) pen. Instructions on the box was to store the medication between 36 and 46 degrees and that it may be stored at room temperature for 14 days.

Six vials of Copaxone (5) 40 gram/1 milliliter. Instructions were to store medication at 36 to 46 degrees.

physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings 5. November 14, 2017

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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1		WINDOWN BROWN BROWN	T	<del>-</del>		OMB N	<u>10. 0938-0391</u>
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU A. BUILO		ONSTRUCTION	(X3) (	DATE SURVEY COMPLETEO
		495362	B. WING	i			C
	PROVIOER OR SUPPLIER  ID NURSING AND RE	HABILITATION	<del> </del>	906 1	ET AOORESS, CITY, STATE, ZIP COOE THOMPSON STREET LAND, VA 23005	1(	09/29/2017
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCEO TO THE APPROFICIENCY)	LILORE	IX5  COMPLETION OATE
F 431	Continued From pa	ge 201	F	131			
	One Novolog (6) fle opened." No specifi	x pen. "Refrigerate until c temperature was given.		-			
	Twelve Promethazi mg suppositories. N	ne HCL (hydrochloride) (7) 25 lo specific instructions given.					
	Nine Marinol (8) 2.5 5 mg capsules with	mg capsules and two Marinol no specific instructions.					
	One Lorazepam (9) were to store the m degrees.	2mg/ml vial. Instructions edication between 36 and 46					-
	Cathfloactivase (10 store between 36 ar	) 2mg. Instructions were to nd 36 degrees.					- <del>-</del>
	(11)- evac 10 mg su 2mg/ml with instruct 77 degrees; Atropin	s containing: Three Biscodyl ppositories; Haloperidal (12) ions to store between 68 and e (13) solution 1% bottle; and (Tylenol) suppositories. With					-
	On 9/28/17 at 1:47 p		-				
	at 2:10 p.m. with OS pharmacist. When a above the recomme affect the medication depends, sometimes would have to call eat to see what the effect of the see what the see what the effect of the see what the effect of the see what the see what the see whet the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the see what the se	s." OSM #8 stated, "You ach individual manufacturer to would be on each drug."					
	On 9/28/17 at 5:00 p	.m. ASM (administrative staff					

member) #1, the administrator/executive director,

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILOING \_ COMPLETEO 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005

F 431 Continued From page 202

PREFIX

TAG

and ASM #2, the director of nursing/clinical services, were made aware of the findings. ASM #1 stated, "It's a new refrigerator. We'll have maintenance check it."

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Review of the facility's policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility Staff should monitor the temperature of vaccines twice a day. 11.2 Refrigeration 36 (degrees) - 48 (degrees)..."

No further information was provided prior to exit.

- 1. Vancomycin Vancomycin is a broad spectrum antibiotic that has activity against methicillin-resistant strains of Staphylococcus aureus and is generally reserved for serious drug resistant gram-positive infections. This information was obtained from: https://livertox.nlm.nih.gov/Vancomycin.htm
- 2. Magic Mouthwash An oral suspension containing diphenydramine hydrochloride, dexamethasone and nystatin, with antihistaminic, anti-inflammatory, and chemotherapy and radiation therapy. This information was obtained from:
- https://www.cancer.gov/publications/dictionaries/cancer-drug?cdrid=632630
- 3. Tuberculin TUBERSOL, Tuberculin Purified Protein Derivative (Mantoux), is indicated to aid diagnosis of tuberculosis infection (TB) in persons at increased risk of developing active

F 431

PREFIX

TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCEO TO THE APPROPRIATE

OEFICIENCY)

[X5] COMPLETION

OATE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILO		CONSTRUCTION	(X3) OAT	E SURVEY IPLETEO
		495362	B. WING	è		1	C
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>		,	ET ACCOUNT OF ATTE TIP COOF	09/	/29/2017
NAME OF .	TOVIDER ON JOINEL.				EET AOORESS, CITY, STATE, ZIP COOE		
ASHLAN	D NURSING AND REI	HARII ITATION		906	THOMPSON STREET		
				ASH	HLAND, VA 23005		
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F 431	Continued From pa	aga 283	F	431			
• • • •	·	_		431			
<u>-</u>		mation was obtained from: m.nih.gov/dailymed/drugInfo.cf					-
							•
		is a hormone produced by the					
		gland that lies near the					
		mone is necessary for the				-	•
		of food, especially sugar.					
		hen the pancreas does not					
	•	lin to meet your body 's needs.					-
	This information wa						
		m.nih.gov/dailymed/archives/fd					•
	aDrugInfo.cfm?arcl	niveid=5696		-			
							÷
		PAXONE (glatiramer acetate					<del></del>
		ed for the treatment of patients					
		s of multiple sclerosis. This					
	information was obt						
		n.nih.gov/dailymed/drugInfo.cf					:
	m?setid=aa88f583-	-4f5f-433b-80b4-1f4c9fb28357				_	-
		DLOG is a rapid acting human			-		
		ated to improve glycemic					
		d children with diabetes		-			
		mation was obtained from:				-	
		m.nih.gov/dailymed/drugInfo.cf					· · · -
		2-3009-40d0-876c-b4cb2be56f					
	c5	- <u>-</u>	-				`-
		<del></del>	-	-			_
	7. Promethazine - F		-				-
	•	vative with histamine -					
		uscarinic, and sedative					
		d as an antiallergic, in pruritus,					
		s and sedation, and also in					
		mation was obtained from:					
		:bi.nlm.nih.gov/compound/pro					į
	methazine#section=	<del>=T</del> op					

8. Marinol - Dronabinol is an orally active

## DEPARTMENT OF HEALTH AND HU...AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		& MEDICAID SERVICES	<del>-,</del>			OME	NO. 0938-0391	
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING				(X3) OATE SURVEY COMPLETEO	
		495362	B. WING				С	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		ET AOORESS, CITY, STATE, ZIF	B 0005	09/29/2017	
ASHIAN	ND NURSING AND RE	HARII ITATION			HOMPSON STREET	- COOE		
740112741		TIADILITA (TOR	İ		LAND, VA 23005			
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTII CROSS-REFERENCEO TO T OEFICIENCY	ON SHOULO BE HE APPROPRIAT	IXS) COMPLETION E OATE	
F 431	•	ge 204 like other cannabinoids, has	F 4	31				
complex effects on the (CNS), including centractivity. Cannabinoid r		the central nervous system ntral sympathomimetic						
	discovered in neura	ll tissues. These receptors					·	
	dronabinol and othe information was obt	nediating the effects of er cannabinoids. This ained from:	-					
	htlps://dailymed.nlm aDrugInfo.cfm?arch	n.nih.gov/dailymed/archives/fd niveid=6035https://dailymed.nl /archives/fdaDrugInfo.cfm?arc					_	
	9. Lorazepam - Lora	azepam tablets are indicated t of anxiety disorders or for	_		-			
	the short-term relief anxiety associated v	of the symptoms of anxiety or with depressive symptoms.					}	
	everyday life usually	ssociated with the stress of does not require treatment his information was obtained						
	https://dailymed.nlm	.nih.gov/dailymed/fda/fdaDru 09ec0-133e-4 <b>7</b> 64-86b9-0435						
		- Alteplase is an enzyme	-					
	(serine protease) that fibrin-enhanced conv	at has the property of			-		, -	
	plasminogen in the a binds to fibrin in a th	limited conversion of absence of fibrin. Alteplase rombus and converts the					-	
		gen to plasmin, thereby lysis (1). This information						
	https://dailymed.nlm. gXsl.cfm?setid=91ed ab3ad9	nih.gov/dailymed/fda/fdaDru cdef2-95ff-42dd-a31c-c8a <b>0</b> 9c						

11. Biscodyl - Bisacodyl is commonly used,

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		& MEDICAID SERVICES			FORM APPROVE
	T OF OE FICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILOI	TIPLE CONSTRUCTION	OMB NO. 0938-039- (X3) DATE SURVEY COMPLETEO
		495362	B. WING		C 00/20/2047
ASHLAN	PROVIDER OR SUPPLIER  ND NURSING AND RE			STREET AODRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	09/29/2017
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO OEFICIENCY)	D.BE COMPLETION
F 431	over-the-counter la: constipation or bow information was obth https://livertox.nih.g  12. Haloperidol - Hain the management disorders. This inforhttps://dailymed.nlmgXsl.cfm?setid=da085de497 13. Atropir parenterally as a predecrease salivation This information wa https://dailymed.nlm	kative used to treat el irregularity. This rained from: ov/Bisacodyl.htm  aloperidol is indicated for use of manifestations of psychotic rmation was obtained from: i.nih.gov/dailymed/fda/fdaDru be2a5-b6f3-4e08-83e8-84b09 ne - Atropine sulfate is given eanesthetic medication to and bronchial secretions.	F 4	31	-
	medication carts in t on unit one.	failed to lock one of nine he facility, the medication cart	- - - :	•	
	was conducted on up.m. with LPN (licens #7 pulled the medica	e medication administration nit one on 9/27/17 at 12:15 sed practical nurse) #7. LPN tion cart up to the resident's resident's resident's room. The door	-		-

to open up the medication cart.

to the room was half closed and LPN #7 could not be observed from the medication cart. LPN #7 - . . was in the room for approximately 45 seconds and then returned to the medication cart. She pulled the lock button out all the way and opened the medication cart. LPN #7 did not use any keys

An interview was conducted on 9/27/17 at 12:20 p.m. with LPN #7. When asked if she had line of

### DEPARTMENT OF HEALTH AND HUIVIAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED С 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X51 PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE OATE DEFICIENCY) F 431 Continued From page 206 F 431 sight to the medication cart when she was in the resident's room, LPN #7 stated, "I was just in there with her and I came back out. The cart was near the door. I thought it was locked." When asked if the locked medication cart could be opened without keys, LPN #7 stated, "I thought it was safe when I went into the room." When asked if she was able to see the cart and this writer when she was in the room, LPN #7 stated, "No." When asked why the medication cart is locked when out of line of sight, LPN #7 stated, "Secure the cart to protect the medications." On 9/28/17 5:00 p.m. ASM (administrative staff member), the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings. Review of the facility's policy titled, "Storage and Expiration Dating of Medications, Biologicals. Syringes and Needles" documented, "PROCEDURE, 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely store in a locked cabinet/cart or locked medication room this is inaccessible by residents and visitors." No further information was provided prior to exit. According to "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc. Page 703. "Make sure that all medications are in locked containers in a room

SS=D PREVENT SPREAD, LINENS

surveillance."

(e.g., medication room) or are under constant

F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL,

F 441

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CTATELIES							APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONST	RUCTION	(X3) DA	. 0938-0391 TE SURVEY MPLETED	
		495362	B. WING				С
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET AL	DDRESS, CITY, STATE, ZIP CODE	<u>  09</u>	/29/2017
А ІНРА	ND NURSING AND RE	HADII ITATIONI			IPSON STREET		
TOTILA	TO NORSING AND RE	HABILITATION			D, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	שפר	(X5) . COMPLETION OATE
F 441	Continued From pa	ae 207	T 44	4		···	
		tion and control program.	F 44	7			
	The facility must es and control prograr a minimum, the foll  (1) A system for presinvestigating, and communicable disevolunteers, visitors, providing services usurrangement based conducted accordinaccepted national simplementation is P	tablish an infection prevention (IPCP) that must include, at owing elements:  venting, identifying, reporting, ontrolling infections and ases for all residents, staff, and other individuals upon the facility assessment g to §483.70(e) and following tandards (facility assessment		1.	The LPN no longer works for the facility that failed to wash her hands during the medication pass with resident #15. The nylon cord attached to the call bell has been replaced. The dried up material has been removed and disinfected behind the		
	<ul><li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li><li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li></ul>				headboard of 301B. The dirty gloves and towels were removed from the sink in Unit 1 shower room.		
	to be followed to pre (iv) When and how is resident; including both (A) The type and dur						-

involved, and

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		E & MEDICAID SERVICES			(	DMB N	O. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) O	DATE SURVEY
		495362	B. WING	;			C
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	9/29/2017
ASHLAN	ND NURSING AND RE	ΉΔ <b>RII ΙΤΔΤΙΛΝ</b>			906 THOMPSON STREET		
					ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (PERCENCY)	DBE	(X5) COMPLETION OATE
F 441	Continued From pa	age 208	F 4	141	1		
	(B) A requirement to	that the isolation should be the		<del>14</del> ,	2. The DCS and or Unit		
	least restrictive pos	ssible for the resident under the			Manager and or		
	circumstances.			٠,	designee completed		
	(v) The circumstant			random medication pass			
	must prohibit emplo disease or infected			observations on all			
		nts or their food, if direct			three shifts with		
		it the disease; and			emphasis on		•
	(vi) The hand hygie	ene procedures to be followed			handwashing.		
		direct resident contact.			Administrator and or		
		A system for recording incidents identified			designee conducted		
	(4) A system for recording incidents identified under the facility's IPCP and the corrective				environmental rounds		
		ons taken by the facility.			on resident rooms for		
	/allinens Person	nel must handle, store,			call bell cords and		
		port linens so as to prevent the			cleanliness of resident		
	spread of infection.				rooms/bathrooms and		•
	(f) Annual review, 7	The facility will conduct an			resident shower rooms.		
	annual review of its	IPCP and update their			Follow up based on		
	program, as necess	sary.			findings.		
	INIS REQUIREMEN by:	NT is not met as evidenced			mang,		
	Based on observati	tion, staff interview and facility					
		was determined that the follow infection control					•
	practices for three o						
	medication pass obs	servation; and in one of 14				•	
		on the Hanover unit and one s on the Hanover unit and one					
	of 3 shower rooms,						
	during the medication	ailed to wash their hands on pass on 9/26/17 at 4:45					
	p.m. for Resident #3	33 and Resident #34 and on					ŀ

9/27/17 at 12:08 p.m. with Resident #15.

PRINTED: 10/12/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					F(	ORM APPROVED
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-039 DATE SURVEY COMPLETED		
		495362	B. WING	·				C
NAME OF	PROVIOER OR SUPPLIER	_		5	STREET ADORESS. C	ITY, STATE, ZIP COO	<u>_</u> <u></u> E	09/29/2017
ASHLAN	ID NURSING AND REI	HABILITATION		9	906 THOMPSON ST	REET		
				1	ASHLAND, VA 23	005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			IX5) COMPLETION E DATE	
F 441	Continued From pa	ge 209	F 4	141	1			
	2. The bathroom between room 306 and 308 was observed to have a brown substance on the nylon cord attached to the call bell on the Hanover Station unit.				3.	The Director o Services and o re-educated li	r desigr	
ļ	3. Dried up feces was observed on the wall							₹,

The findings include:

1. The facility staff failed to wash their hands during the medication pass on 9/26/17 at 4:45 p.m. for Resident #33 and Resident #34 and on 9/27/17 at 12:08 p.m. with Resident #15.

behind the headboard of the second bed (B-bed)

4. The unit one shower room was observed with

in room 301 on the Hanover Station unit.

dirty gloves and towels in the sink.

Resident #33 was admitted to the facility on 7/6/15 with diagnoses that included but were not limited to: high blood pressure, arthritis, anemia and muscle weakness. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 7/3/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

Resident #34 was admitted to the facility on 8/31/12 with diagnoses that included but were not limited to: dementia, low blood pressure and blood vessel disease. The most recent MDS, a quarterly assessment, with an ARD of 7/15/17 coded the resident as having scored a three out of 15 on the BIMS, indicating the resident was

nurses on hand washing prior to Medication administration. The Administrator and or designee re-educated housekeeping staff on cleaning call bell cords, cleaning resident rooms and Shower rooms. Nursing staff educated on role of maintaining resident rooms, resident bath rooms and resident shower rooms in a clean and orderly condition. Facility IDT to complete customer service rounds weekly for cleanliness of resident rooms and bathrooms and report using Mock Survey Tool.

PRINTED: 10/12/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FO	RM APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
		495362	B. WING_			C 0 <u>9/29</u> /2017
	(EACH DEFICIENCY	HABILITATION  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	(EACH CORRE	Y, STATE, ZIP CODE  EET  D5  S PLAN OF CORRECTION COUNTY OF THE PROPERTY OF TH	[X5]
F 441	Continued From parseverely impaired of Resident #15 was a 10/3/16 with diagnor limited to: seizures, disease, diabetes, histoke. The most resident as having a BIMS (brief interview the resident was condecisions.  An observation of the ori 9/26/17 at 4:45 practical nurse) #7. medications for Resident was condecisions.  An observation of the ori 9/26/17 at 4:45 practical nurse) #7. medications for Resident was condecisions.  An observation of the ori 9/26/17 at 4:45 practical nurse) #7. medication cup. LPN water. LPN #7 then room and gave the roup to the resident. Taking the medication uniform pocket and she applied to her lip back into her pocket plastic cups from the them. LPN #7 washed the medication cart. Into a plastic water of then used the cup shand filled it with water medication room to condecision or the condecision or the condecision or the condecision or the condecision or the condecision or the condecision or the condecision or the cup shand filled it with water medication room to condecision.	ge 210	F 44	4. The D Manag design quality handw Medica per we then w weeks Admini Housel Superv designe quality bell con	CS and or unit ger and or lee to conduct monitoring of the monthly. Istrator and or lee to conduct when monthly. Istrator and or lee to conduct monitoring call rds, cleanliness of and cleanliness	OATE

the medication cup and then took the medication and cup of water into Resident #34's room, she gave the resident the medication and water cups and then took them from the Resident #34 and

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				FOR!	MAPPROVEC
	IT OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTI	TON	(X3) OA	D. 0938-0391 ATE SURVEY IMPLETEO
		495362	B. WING_			00	C
NAME OF	PROVIOER OR SUPPLIER			STREET AOORES	SS, CITY, STATE, ZIP COOE	<u>  _u</u>	9/29/2017
ASHLAN	ND NURSING AND REI	HABILITATION		906 THOMPSON	N STREET		
				ASHLAND, VA	23005		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	IO PREFIX TAG	K (EACH)	IVIOER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULO REFERENCEO TO THE APPROPI OEFICIENCY)	) BE	IX5) COMPLETION OATE
	hands after going in obtaining the medic Resident #34 the m An observation of the Resident #15 was mouth LPN #7. LPN # one tablet, Seroque oxycodone (5) 5 mg medication cup. LPI with water and took medication cart. A c LPN #7 picked up the one the medication cart. A c LPN #7 picked up the one the medication into Redid not discard the spicking the straw up An interview was cop.m. with LPN #7. We their hands, LPN #7 working with the resistaff washed their hards and returning to the stated, "I should hav made aware of using and then taking the refrom the resident, LF probably not good." I straw on the floor an cup on the medication her hands, LPN #7 s	PN #7 did not sanitize her not the medication room and cation and before giving nedication.  The medication pass for made on 9/27/17 at 12:08 p.m. #7 placed Renvela (3) 800 mg el (4) 200 mg one tablet and g/325 mg one tablet into a place of the floor. The straw from the cup on the covered straw fell to the floor. The straw, put it back in the cup cart and then took the esident #15's room. LPN #7 straw or wash her hands after to off the floor.  The did a plastic cup of the floor. The straw or wash her hands after to off the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor.  The did a plastic cup of the floor of the floor of the floor.  The did a plastic cup of the floor of the f	-	41	of shower rooms. Quality monitoring to conducted 3X a weet per week for 4 week ensure compliance at then 1X a week for 4 weeks then quarterly thereafter. Quality monitoring schedules be modified based of findings of quality reviews. The results the quality monitoring to be reviewed at the monthly Quality Assurance Performation Improvement (QAPI meetings for review analysis and further recommendations.	ek ks to and 4 ly e to on s of ing ne	
	her hands, LPN #7 stated, "I should have thrown it away and washed my hands."						

An interview was conducted on 9/28/17 at 8:40

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
	ATEMENT OF OEFICIENCIES (X1) PROVIOEP/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OA	). 0938-0391 TE SURVEY MPLETEO			
		495362	B. WING				С
NAME OF	PROVIOER OR SUPPLIER		<u>,                                     </u>	STI	REET AOORESS, CITY, STATE, ZIP COOE	09	/29/2017
ACUL AN	ID NUDCING AND DE	UADU ITATION			THOMPSON STREET		
ASILAN	ID NURSING AND REI	HABILITATION			HLAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF OEFICIENCY)	O DE	(X5) COMPLETION DATE
	a.m. with ASM (adn the director of nursi asked when staff w stated, "After every periodically through what staff should do floor, ASM #2 state was made aware of Review of the facilit "Handwashing" doc component of infect All staff members of the following proced No further information No further information in Fundamentals of and Wilkins page 14 washing and the use hands are conduits potential pathogens from a contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient contaminated a staff member to the single most important patient pa	ninistrative staff member) #2, ng/clinical services. When ashed their hands, ASM #2 patient encounter and out the day." When asked of there was a straw on the d, "Throw it away." ASM #2 the findings at that time.  y's policy titled, umented, "Policy: An essential ion control is hand washing. nust wash their hands using	F 4	41			
	1. Gabapentin - Gab	apentin capsules, are ement of post herpetic					

neuralgia in adults

Adjunctive therapy in the treatment of partial

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) D	(X3) DATE SURVEY COMPLETED	
				<del></del>		С	
		495362	B. WING	<u> </u>	<u> </u>	9/29/2017	
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 906 THOMPSON STREET ASHLAND, VA 23005	ODE	5/25/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	( THE TOTAL PORT OF THE PROPERTY OF THE PROPER	I SHÓLLI D RE	IX5I COMPLETION DATE	
F 441	Continued From pa	ge 213	· F	441			
	generalization, in ac years and older with was obtained from: https://dailymed.nlm	n and without secondary dults and pediatric patients 3 n epilepsy This information n.nih.gov/dailymed/drugInfo.cf d615-43a2-8989-898fe11f90df	-				
	for oral administration obtained from: https://dailymed.nlm	ohalexin, USP is a alosporin antibiotic intended on. This information was n.nih.gov/dailymed/fda/fdaDru cc3f8b-51d1-4d74-a4ee-9240c					
	treatment of schizop obtained from: https://dailymed.nlm	QUEL is indicated for the chrenia. This information was .nih.gov/dailymed/drugInfo.cf bc3c-48fe-1a90-79608f78e8a					
	pure opioid agonist vaction is analgesia. from:	codone is a semisynthetic whose principal therapeutic This information was obtained .nih.gov/dailymed/archives/fd iveid=17971	÷				
	observed to have a t	ween room 306 and 308 was prown substance on the nylon call bell on the Hanover					

PRINTED: 10/12/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) DATE SURVEY COMPLETED
		495362	B. WING	<del></del>	C
NAME OF	PROVIOER OR SUPPLIER		<del>'</del>	STREET AOORESS, CITY, STATE, ZIP COO	
ASHLAN	ND NURSING AND RE	HABILITATION	İ	906 THOMPSON STREET ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE COMPLETION
F 441	Continued From pa	ge 214	F 4	41	
	was conducted. The was shared with rocall bell was located. The nylon string att covered with a brown on 9/26/17 at 3:00 conducted with CN. #12, a CNA on the lasked what she wonylon string to the cashe would contact rappiy a new string, into the bathroom sobserved the call bethe call bell string a was brown. CNA # was on the nylon string was unsanitary for the brown call bell.  On 9/27/17 at 8:15 amember) #12, the hollowed (his writer is 308. When asked wattached to the call.	p.m., observation of room 308 that on 306 was observed. The don the wall next to the toilet, ached to the call bell was vn substance.  p.m., an interview was A (certified nursing assistant) Hanover Station unit. When uld do if she noticed a dirty tall bell, CNA #12 stated that maintenance to have them CNA #12 followed this writer hared by 306 and 308 to bell string. CNA #12 observed and stated the call bell string 12 could not determine what ring. CNA #12 stated that it he residents to be using the a.m., OSM (other staff tous ekeeping director, into the bathroom of room what color the nylon string bell should be, OSM #12 en asked what he noticed			

about the nylon string, OSM #12 stated the cord was brown and needed to be replaced. OSM #12 stated he would replace the call bell string immediately. OSM #12 stated that he was not

On 9/28/17 at 5:15 p.m., ASM (administrative

director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made

sure what the brown substance was.

staff member) #1, the executive

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMR N	IO. 0938-0391
	OF OFFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		CONSTRUCTION	(X3) D	DATE SURVEY COMPLETED
<u>.</u>		495362	B. WING	;		,	C 09/29/2017
	PROVIDER OR SUPPLIER	HABILITATION		906	REET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005	1. 0	13123120   7
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PRÖVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	IX5) COMPLETION OATE
F 441	aware of the above	ge 215 concerns. No further esented prior to exit.	F	441			
	observed on the wa	eces like substance was all behind the headboard of the ) in room 301 on the Hanover	<b>:</b>				-
	was conducted. Two observed behind the measuring the goughoticed a foul odor.	p.m., observation of room 301 to large gouges were e second bed. While eges in the wall; this writer and dried up brown feces like the wall behind the headboard		· .			
	was made of room	p.m., a second observation 301. Dried up brown feces ained stuck to the wall behind e bed.			•		
	conducted with CNA #12. When asked h on the resident's roc 2 hours." When ask for on her rounds, C checks on the resid cleanliness of the ro- last time she went in she was in room 30 When asked if she in the room, CNA #12 followed this writer i	o.m., an interview was (certified nursing assistant) ow often CNAs made rounds oms, CNA #12 stated, "Every ked what Resident #12 looks NA #12 stated that she ents and looks at the oms. When asked when the to room 301, CNA #12 stated 1 at approximately 3:30 p.m. noticed anything unusual in stated, "No." CNA #12 http://www.noticed.com/s01. When asked hind the head board of the					

second bed, CNA #12 stated, "That looks like BM (bowel movement). It looks very old and dry."

PRINTED: 10/12/2017

CENTERS	S FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVE OMB NO. 0938-039		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SU		
		495362	B. WING				09	C /29/2017
	NURSING AND RE	HABILITATION		906 TH	TADDRESS. CITY. STATE, ZIP C IOMPSON STREET AND, VA 23005	ODE	<u> </u>	.20,2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y STATEMENT OF DEFICIENCIES ID ENCY MUST BE PRECEDED BY FULL PREFIX OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ASHOULD	BE	(X5) COMPLETION DATE
C C	CNA #12 stated that unsanitary. CNA # emoved the feces	eces on the wall is a concern, at feces on the wall was 12 then took a paper towel and from the wall. CNA#12 per that was across the hall to	F 4	41				

On 9/26/17 at 4:33 p.m., an interview was conducted with OSM (other staff member) # 13, the housekeeping director. When asked how often housekeeping made rounds in resident rooms on the dementia unit, OSM #13 stated-that housekeeping rounded on resident rooms at least four times a day on the dementia unit. OSM #13 stated that he tries to round at least every hour. When asked what he checked while rounding. OSM #13 stated that he checked rooms, floors. and bathrooms for cleanliness. OSM #13 also stated that each room received a deep cleaning on certain days of the weeks. When asked if rounding and deep cleaning included checking behind and under the beds, OSM #13 stated that sometimes he will check behind the beds and he always checks underneath the beds. A copy of the deep cleaning schedule was requested.

On 9/26/17 at approximately 6 p.m., the deep cleaning schedule was presented. Room 301 received a deep-cleaning on 9/1/17.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns. No further information was presented prior to exit.

PRINTED: 10/12/2017 FORM APPROVED OMB NO 0938-0301

		A MEDICAID SERVICES				OMB NO	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER;			CONSTRUCTION	(X3) O	ATE SURVEY DMPLETEO
		495362	B. WING				С
NAME OF I	PROVIOER OR SUPPLIER		1			_   _ 0	9/29/2017
					ET ADORESS, CITY, STATE, ZIP CODE		
ASHLAN	ID NURSING AND REI	HABILITATION			THOMPSON STREET		
				ASH	ILAND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES  / MUST BE PRECEDEO BY FULL  SC IDENTIFYING INFORMATION)	IO PREFII TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCEO TO THE APPRI OEFICIENCY)	II O BE	(X5) COMPLETION DATE
F 441	Continued From pa	ae 217	F 4	14			
		ower room was observed with	Г4	41			
	dirty gloves and tow						
	anty giorocana lon	TOTO III III O SIIIK.					* .*
	On 9/26/17 at 4:05	p.m., observation of the					
		conducted. On 9/16/17 at					~ -
		One shower room was					
	observed. Dirty tow	vels and used gloves was	٠.				
	observed in the sink	of the shower room.	-				
	0 00000						-
		p.m., an interview was					
		A (certified nursing assistant)					
		when the shower rooms were stated that the nursing aides					
	Were supposed to c	lean the shower rooms after	-	•			4.5
		CNA #13 stated that nursing					
		the shower chairs and place					
		els in a trash bag to be taken					
		rel. CNA #13 stated that					*
	trash should also be	e bagged separately and		٠.			
		in immediately after a shower.	-				
		s ever ok to leave trash and	-				-
		he shower rooms, CNA #13					-
		ot. When asked if she could			•		
		was in the sink of the shower	•				- [
		ed, "Something that shouldn't diately placed on gloves and	-	•			
		owels and gloves from the					İ
		when the last time the shower					
		A #13 stated that it must have					
		CNA #13 stated that she had					]
		at 3 p.m. for evening shift.					İ
	•	_					
		o.m., ASM (administrative					
	staff member) #1, th						.
		or and ASM #2, the DON					Ţ
	(Director of Nursing) aware of the above	/clinical services, were made concerns.					

The facility policy titled, "Handling of soiled linen"

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTR	UCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	1	ING		COMPLETED
		495362	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	J. 77110		DRESS, CITY, STATE, ZIP CODE	09/29/2017
ACULAN	ID MUDOING AND DE	LABILITATION.			SON STREET	
ASHLAN	ID NURSING AND REI	HABILITATION			, VA 23005	
(X4) IO PREFIX		TEMENT OF OEFICIENCIES  MUST BE PRECEDEO BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD	(7.5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		SS-REFERENCED TO THE APPROP DEFICIENCY)  F502	DBE COMPLETION RIATE DATE
F 441			F	141	1.Resident#2 suffere	e <b>d</b>
		the following: "Policy: To rage the concept that all			no adverse effects ar	nd ,
	sciled linen is consi				did not require trans	
		cedure: Do not sort or			to a higher level of ca	
		n in the resident areas. ene, Don Gloves, Place dirty			A physician order wa	
	linen into bad (caret	fully, not to touch outside of	-		obtained to discontir	
		s, perform hand hygiene, place bag in designated barrel			Resident #'s order fo	r .
		utility room. Perform hand	-		Urinalysis. The Physic	
F 500	hygiene."	HOZD LTIGAL			and responsible party	y
F 502 SS=D	483.50(a)(1) ADMIN	NISTRATION	F 5	502	were notified. Reside	ent J
30-D	(a) Laboratory Servi	ices			#15 suffered no adve	rse
	(1) The facility must	provide or obtain laboratory			effects and did not	
		e needs of its residents. The			require transfer to	
		e for the quality and timeliness			higher level of care. A	١
	of the services. This REQUIREMEN	IT is not met as evidenced	,		Physician order for w	as
	by:			. <u>.</u>	obtained for Resident	t -
		view and clinical record mined that the facility staff			#15's order for Sputu	m
		ratory specimens for two of 34			culture to be	·
	residents in the surv	rey sample, Resident #2 and			discontinued. The	
	Resident #15.				Physician and	
		ailed to obtain a urine			responsible party	-
	specimen for Reside physician on 5/30/17	ent #2 as ordered by the			received notification	
		ailed to obtain a sputum			2.A quality review of	
	culture from Resider physician on 9/21/17	nt #15 as ordered by the	•		current residents with	,
	physician on arz I/ I/	•			physician orders for	
	- a				laboratory testing has	
	The findings include	;			been performed.	
					Physician notification	

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CENTER	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			OMB NO. 0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	5	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495362	B. WING_		C 09/ <b>29/201</b> 7
NAME OF I	PROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP CODE	
ASHLAN	ND NURSING AND REI	HABILITATION		906 THOMPSON STREET	
				ASHLAND, VA 23005	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	ILO RE COMPLETION
F 502	Cantinued From no	040	=	*	
1 502	Continued From pa	s admitted to the facility on	F 50:	2 related to laboratory	
	5/1/17 with diagnos	ses that included but were not		results is in present in	1
	limited to: HIV (hum	nan immunodeficiency virus		the chart.	I
		ression, difficulty swallowing sterol. The most recent MDS			
	(minimum data set)	), a quarterly assessment, with		3.Licensed Nurses re-	
		ent reference date) of 8/8/17		educated by	
		as having both short and long. ems and as severely impaired		•	·
	cognitively. Resider	nt #2 was coded as rarely or		DCS/Designee regardi	ng
		understand others or to be		following Physician	
		sident was coded as requiring aff for all activities of daily		orders on obtaining	
,Z	living.			laboratory specimen	
	Stanton of the resid			and the process in	
		ent's care plan developed on ess obtaining urine specimens.		following up with	
				laboratory results	
		t #2's physician orders dated		including Physician and	d
*-	് വെ 5/26/17 docume (urine and analysis)	nted, "Clean Catch U + A		RP notification.	
		•		DCS/Designee during	
		al record did not evidence		Morning Clinical	•
	documentation of th	ne urine specimen results		Meeting to conduct	
		e on 9/27/17 at 1:45 p.m. of		quality monitoring of	
		e staff member) #1, the		physician laboratory	
	Resident #2's urine	utive director, for a copy of specimen results.		orders, contacting the	
		·		Physician and RP	
		onducted on 9/28/17 at 10:58		notification daily x4,	
		he director of nursing/clinical tated, "I don't have the lab.		weeklyx4 and then	
	(laboratory specime	en) which is why the order was			
		staff obtained an order to		monthly, PRN and as	
_	discontinue the urine	e specimen order on 9/27/17.)		indicated,	
	Review of the facility	y's policy titled, "Laboratory,			

Diagnostic and X-Ray" did not evidence

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO	.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495362	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	09/	/29/2017
ASHLAN	D NURSING AND RE	HABILITATION			THOMPSON STREET		
				_ASH	LAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) RE	(X5) COMPLETION OATE
F 502	Continued From pa	ge 220	F 5	02			
		arding notifying the physician if to obtain a laboratory					
	No further informati	on was provided prior to exit.			4.DCS/Designee to		
					conduct quality		
-	1. HIV stands for h	uman immunodeficiency virus,			monitoring regarding		
	which is the virus th	at causes HIV infection. The			physician notification		· ·
		can refer to the virus or to HIV virus that causes HIV	•		with documentation in		
		e most advanced stage of			the medical record as		
	HIV infection.	ala a a a a a a a a a a a a a a a a a a			indicated. Findings to be		,
		gh contact with the blood, I fluid, rectal fluids, vaginal			communicated to the	••	
	fluids, or breast mill	of a person with HIV. In the			QAPI committee		
		s spread mainly by having or sharing drug injection	•		monthly and as		
	equipment with a pe				indicated. Quality		
		y (ART) is the use of HIV			monitoring schedules		
		IIV infection. People on ART of HIV medicines (called an			modified based on		
	HIV regimen) every	day.			findings		
	people with HIV live	infection, but it can help longer, healthier lives. HIV			5. November 14, 2017		
	medicines can also	reduce the risk of . This information was					
	obtained from the w						
		ov/understanding-hiv-aids/fac					Example 1
	t-sheets/19/45/hiv-a	IOSthe-basics			<del></del>		
		ailed to obtain a sputum ty as ordered on 9/2/17 for					-
		dmitted to the facility on ses that included but were not					

limited to: seizures, schizophrenia, kidney

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	10 I OK MEDICAKE	A MILDICAID SERVICES	<del></del>			0	MB NO.	<u>. 0938</u> -0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONS	STRUCTION	<u> </u>	(X3) OAT	E SURVEY IPLETEO
		495362	B. WING				1	C
NAME OF F	PROVIOER OR SUPPLIER	<u> </u>		STREET	ADDRESS CI	TY, STATE, ZIP CODE	1 09/	29/2017
ļ.					MPSON STR			
ASHLAN	D NURSING AND RE	HABILITATION						
				ASHLA	ND, VA 230	105		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES  Y MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCEO TO THE APPROPI OEFICIENCY)	RF	(X5) COMPLETION DATE
	Continued From particles disease, diabetes, stroke. The most reassessment, with a resident as having: BIMS (brief intervie the resident was condecisions. Resident assistance from stalliving.  Review of Resident 10/13/16 and revised documentation relarspecimens.  Review of the physical documented, "Obtasensitivity) on Tuesconding was made of ASM #1, the admining a copy of the sputure. An interview was conducted." (The discontinued." (The discontinue the sputures.	nigh blood pressure and event MDS, a quarterly in ARD of 7/7/17 coded the scored a 13 out of 15 on the w for mental status) indicating ignitively intact to make daily the #15 was coded as requiring iff for all activities of daily with #15's care plan initiated on ead on 7/26/17 did not evidence ted to obtaining sputum characteristic culture and day (9/5/17)."  all record did not evidence the sputum specimen results. A pm 9/27/17 at 1:45 p.m. of strator/executive director, for m specimen results.  Inducted on 9/28/17 at 10:58 the director of nursing/clinical stated, "I don't have the lab in) which is why the order was staff obtained an order to turn specimen on 9/27/17.)	F	502	F504	A physician orde obtained for the (basic metabolic blood test) and la has been obtain resident #10. Ph	r been e BMP panel) ib work ned for	
			F 5	504		was notified of	results	-
	, ,							ŀ

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	NOT OTT THE BUSY A VE	T CAMEBION OF SERVICES	τ	<del></del>		O	JMB NC	<u>0. 0938</u> -0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA ICENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CO	NSTR	UCTION	(X3) DA	TE SURVEY
		495362	B. WING				0,	C
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREE	TADE	DRESS, CITY, STATE, ZIP CODE	1 05	/29/2017
						SON STREET		
ASHLAN	ID NURSING AND RE	HABILITATION						
	<del></del>			ASHL	עאא	, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG	×	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	7 RE	(X5) COMPLETION DATE
F 504	Continued From pa	age 222	· F 5	04		-		
	(2) The facility mus		ı J	04				
	(2) The facility mus	_						
	(i) Provide or obtain	laboratory services only when				and he did not give any		
1		cian; physician assistant; nurse		•		new orders.		-
		cal nurse specialist in			2			
		ate law, including scope of			۷.	The Director of Clinical		
	practice laws.	·				Services or designee has		
		NT is not met as evidenced				reviewed current		
	by:		·			Guilent		
}	-	rview, clinical record review,				resident's physician		
ĺ		nt review, it was determined				orders to ensure the		
	that the facility staff	failed to obtain a physician's				physician was notified		
] ,	order prior to obtain	ning a laboratory test for one of	-					•
	34 residents in the	survey sample; Resident #10.				of results.		
,					3.	The Director of Clinical		. **
<i>}</i> ₹	The facility staff fail	ed to obtain a physiciarı order				Services or designee re-		
ľ		(basic metabolic panel) blood						
	test on 4/5/17 for R	esident #10.				educated licensed		
						nursing staff on		-
	The findings is sinds	<u>.</u> .				ensuring physician		
	The findings include	<b>5.</b>		•		- , , , , , , , , , , , , , , , , , , ,		-
	Resident #10 was a	edmitted to the facility on				orders are written prior		
		rission date of 9/14/14 with				to the resident receiving		
		uded, but were not limited to:				lab services.		
	dementia, difficulty	swallowing, convulsions,				140 301 11003.		
!	depression and psy							, 44
				ľ				: ]
	Resident #10's mos	t recent MDS (minimum data						·
	set), a quarterly ass	essment with an ARD						
		nce date) of 7/6/17, coded	-					
		ing unable to complete the						
		w for mental status). The staff						}
	assessment of Resi	dent #10's cognitive status						
		(three) indicating that					•	į
		everely cognitively impaired						
		naking. Resident #10 was -				, No.		
	also coded as requir	ring extensive assistance of						ĺ

one to two staff members for all activities of daily

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0	FORM APPROVED
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILO		CONSTRUCTION		VIB NO. 0938-0391 (X3) OATE SURVEY COMPLETEO
		495362	B. WING	;	•		С
NAME OF	PROVIOER OR SUPPLIER		<u> </u>		EET AODRESS, CITY, STATE, ZIP	0005	09/29/2017
ASHLAN	D NURSING AND RE	HABILITATION		906	THOMPSON STREET HLAND, VA 23005	COOE	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH OEFICIENCY	) N SHOULO IE APPROPI	BE COMPLETION
	understood when c A review of Resider revealed a laborato 4/5/17 without a cor A review of Resider summary dated 8/3 following laboratory (six) months (may a summary dated 8/3 following laboratory (six) months (may a summary dated 8/3 following laboratory (six) months (may a summary dated 8/3 following laboratory (six) months (may a summary dated 8/3 following dated 8/3 following dated 8/3 following dated 8/3 following dated 8/3 following dated 8/3 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/4 following dated 8/3 following dat	understanding or being ommunicating with others.  Int #10's clinical record ry result for a BMP dated responding physician order.  Int #10's physician order order.  Int #10's physician order orders; "Labs: BMP every 6 orders; "Labs: BMP every 6 orders; "Labs: BMP every 6 orders, "Labs: BMP every 6 order was received to obtain the order was received to obtain the order was received to obtain the order was unable to locate an lo's clinical record for the asked if an order was laboratory test, ASM #2 quired.  In a.m., ASM #1, the executive aware of the above concern. Ited at this time regarding tests.  Ity document titled stic and X-Ray" revealed, in ocumentation; "Procedure: order for laboratory work, or the stic and tests.		504	4. The Director Services and o to conduct monitoring of orders. monitoring conducted 3x per week for 4 ensure compl then 1X a will weeks then thereafter. Monitoring so be modified findings of reviews. The the quality in to be review monthly Assurance Per Improvement meetings for analysis and recommendati	of Clinic r designe quality physicia Quality to be weeks to a week for Quality physical and a the Quality formance (QAP review further ons.	tee ty ty ty ty tee tk to to td ty ty to to tr ty to tr tr ty to tr tr tr tr tr tr tr tr tr tr tr tr tr
	No further information	on was provided prior to the ocess.			5. November 14,	2017	

[1] BMP is a blood test that measures your sugar

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_\_\_ COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 504 Continued From page 224 F 504 (glucose) level, electrolyte and fluid balance, and F507 kidney camera.gif function. This information was 1. The Depakote level obtained from the following website: http://www.webmd.com/a-to-z-guides/tc/basic-me results dated 8/30/17 tabolic-panel-topic-overview was filed in resident #1's F 507 483:50(a)(2)(iv) LAB REPORTS IN RECORD -F 507 clinical record and the ss=D LAB NAME/ADDRESS Depakote level was (a) Laboratory Services within normal limits. (2) The facility must-The CBC (complete blood count) results (iv) File in the resident's clinical record laboratory dated reports that are dated and contain the name and 7/5/17 address of the testing laboratory. resident #17 has been This REQUIREMENT is not met as evidenced filed in the resident's by: Based on staff interview, facility document review clinical record and the and clinical record review, it was determined that -CBC was within normal the facility staff failed to file laboratory results in limits. the clinical record for two of 34 residents in the survey sample, Residents #1 and #17. 2. Medical Records has reviewed 1. The facility staff failed to file Resident #1's current Depakote level results dated 8/30/17 in the residents' clinical clinical record. records for labs filed in 2. The facility staff failed to file Resident #17's the clinical record for CBC (complete blood count) results dated 7/5/17 the past year. in the clinical record. 3. The Administrator and

clinical record.

The findings include:

1. The facility staff failed to file Resident #1's Depakote level (1) results dated 8/30/17 in the

or designee re-educated

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM MR NO	1 APPROVED 0. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			DNSTRUCTION	(X3) OA1	TE SURVEY MPLETEO
		495362	B. WING			09	C /29/2017
NAME OF	PROVIOER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP COOE	, , , , ,	
ASHLAN	ID NURSING AND REI	HABILITATION			HOMPSON STREET LAND, VA 23005		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	<b></b>	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	DBF	(X5) COMPLETION OATE
F 507	Resident #1 was as 3/28/16. Resident were not limited to: blindness. Resider (minimum data set) assessment with as date) of 8/4/17, cookills for daily decis impaired.  Review of Resident physician's order dalevel to be obtained the resident's clinic results of a Depaktor of Depakto	dmitted to the facility on #1's diagnoses included but repeated falls, dementia and nt #1's most recent MDS ), a significant change in status n ARD (assessment reference led the resident's cognitive	F 5		Medical records staff on filing labs on the clinical records to ensure compliance is attained and maintained regarding filing labs on clinical records.  The Administrator and or designee to conduct Quality monitoring of filing labs in the clinical records. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter.		

aware of the above concern.

On 9/27/17 at 6:10 p.m. ASM #1 (the executive director/administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made

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		E & MEDICAID SERVICES	т		OMB NO.	0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) OATI	E SURVEY PLETEO
	:	495362	B. WING _			C
	PROVIOER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	1 097	29/2017
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL .SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT	II O BE	(X5) COMPLETION DATE
F 507	Continued From pa	ige 226	F 50	)7		
A STATE OF THE STA	and X-Ray" docume diagnostic testing a medical record"  No further informati  (1) Depakote is use mood disorders and Depakote level is a the medication in the therapeutic drug level obtained from the white hot medication in the white hot medication in the therapeutic drug level obtained from the white hot medication in the white hot medication in the white hot medication in the white hot medication in the white hot medication in the white hot medication in the clinical and heart failure. Resident #17 was an 1/28/17. Resident # were not limited to: fand heart failure. Resident # an ARD (assess 8/7/17, coded the resintact.  Review of Resident a physician's order of 7/5/17. Further reviewer for the resident in the physician's order of 7/5/17. Further reviewer for the formal medication in the formal medication	vel. This information was vebsites:		Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.  5. November 14, 2017		

On 9/27/17 at 5:19 p.m. an interview was

### DEPARTMENT OF HEALTH AND HUMAN SERVICES. PRINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED C 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLÉTION TAG TAG CRDSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 507 Continued From page 227 F 507 conducted with LPN (licensed practical nurse) #6 (unit manager) regarding the filing of laboratory results in the clinical record. LPN #6 stated. "Sometimes I have to do it. It's an ongoing process. Nurses try to get to it. I go through the doctor's book and clean out the ones signed. We file as many as we can." On 9/28/17 at 2:35 p.m., per this surveyor's request, ASM (administrative staff member) #1 (the executive director/administrator), presented the results for Resident #17's CBC obtained on 7/5/17. The fax date at the top of the results was 9/28/17. ASM #1 confirmed the results were faxed to the facility and were not present in the clinical record. On 9/29/17 at 9:45 a.m., ASM #1 and ASM #2 (the director of clinical services/nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "A complete blood count (CBC) test measures the following: The number of red blood cells (RBC count) The number of white blood cells (WBC) count) The total amount of hemoglobin in the blood The fraction of the blood composed of red

(b) Radiology and other diagnostic services.

F 513 483.50(b)(2)(iv) X-RAY/DIAGNOSTIC REPORT

obtained from the website:

blood cells (hematocrit)..." This information was

https://medlineplus.gov/ency/article/003642.htm

SS=D IN RECORD-SIGN/DATED

F 513

### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495362 B. WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL [X5] PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 513 Continued From page 228 F 513 (2) The facility must-(iv) File in the resident's clinical record signed and F513 dated reports of radiologic and other diagnostic 1. The chest x-ray dated services. This REQUIREMENT is not met as evidenced 9/19/17 for resident #1 has been filed in the Based on staff interview, facility document review resident's clinical and clinical record review, it was determined that the facility staff failed to file x-ray reports in the record. clinical record for two of 34 residents in the 2. Medical Records has survey sample, Resident #1. reviewed current The facility staff failed to file Resident #1's chest resident's clinical x-ray results dated 9/19/17 in the resident's records for x-rays filed clinical record. in the clinical record for the past year. The findings iriclude: 3. The Administrator and Resident #1 was admitted to the facility on or designee re-educated 3/28/16. Resident #1's diagnoses included but Medical Records staff were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS on filing x-ray results (minimum data set), a significant change in status timely to include newly assessment with an ARD (assessment reference

Review of Resident #1's clinical record revealed a physician's order dated 9/18/17 for a STAT (immediate) chest x-ray. Further review of Resident #1's clinical record failed to reveal the results of the chest x-ray.

date) of 8/4/17, coded the resident's cognitive

skills for daily decision making as severely

On 9/27/17 at 12:05 p.m., per this surveyor's request, ASM (administrative staff member) #1 (the director of clinical services/nursing)

compliance is attained maintained regarding filing labs on

clinical record.

impaired.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE (	CONSTRUCTION	<u>_</u> <u>_</u>	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:				<del>_</del>	COMPLETED
		495362	B. WING	:			С
NAMEGE	PROVIDER OR SUPPLIER	40002	L. Mine		SEET ADDRESS SITE OF		09/29/2017
	D NURSING AND RE			906	EET ADDRESS, CITY, S THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	-	(EACH CORRECT) CROSS-REFERENC	AN OF CORRECTIOI IVE ACTION SHOULD ED TO THE APPROPI FICIENCY)	BE COMPLETION
F 514	9/19/17. The fax da was 9/27/17. ASM faxed to the facility clinical record for the On 9/27/17 at 5:19 conducted with LPN (unit manager) regain the clinical record I have to do it. It's a try to get to it. I go clean out the ones awe can."  On 9/27/17 at 6:10 director/administrative gional director of aware of the above. The facility policy tit and X-Ray" documed diagnostic testing a medical record"  No further informatic 483.70(i)(1)(5) RES	ts of a chest x-ray dated ate at the top of the results ate at the top of the results ate at the top of the results because she looked in the results but didn't see them.  p.m. an interview was I (licensed practical nurse) #6 arding the filing of x-ray results I. LPN #6 stated, "Sometimes an ongoing process. Nurses through the doctor's book and signed. We file as many as p.m. ASM #1 (the executive or), ASM #2 and ASM #3 (the clinical services) were made concern.  Iled, "Laboratory, Diagnostic anted, "Laboratory work, and x-rays to be filed in the		513		The Administ or designee to Quality monifiling of x-ray the clinical Quality Monibe conducted per week for a ensure completion 1X a month an quarterly Quality is schedule to be based on fi quality reviewed at the Quality Performance	o conduct itoring of results in record. itoring to 3X a week 4 weeks to iance and week per d then thereafter. monitoring e modified ndings of ws. The ne quality to be ne monthly Assurance
	(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-				5.	Improvement meetings fo analysis and recommendat Date of compl	further ions.
	(i) Complete;						<del>-</del> -

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<u> </u>	COT CITIVILLE ION AND	A MILDIONID OLIVICES	т				OMB N	<u>O. 0938-03</u> 91
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTIO	(X3) OATE SURVEY COMPLETEO		
		495362	B. WING					C 0/20/2047
NAME OF I	PROVIOER OR SUPPLIER		<u> </u>	STR	EET AOORESS	S, CITY, STATE, ZIP CODE	_ 10	9/29/2017
		LABITATION			THOMPSON			
ASHLAN	D NURSING AND REI	HABILITATION			HLAND, VA			
(X4) ID	SLIMMARYSTA	TEMENT OF OFFICIENCIES						
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI) TAG	×	(EACH C	DER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU FERENCEO TO THE APPRI OEFICIENCY)	II O BE	IX5) COMPLETION DATE
F 514	Continued From pa	ige 230	F 5	14				
	(ii) Accurately docu	-	, ,	1-7				
	(,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			F514			
	(iii) Readily accessible; and					D = -1-1		
(iv (5 (i)					1.	Resident # 4 re	ceives	
	(iv) Systematically (				treatments	per		
	<ul><li>(5) The medical record must contain-</li><li>(i) Sufficient information to identify the resident;</li></ul>					physician c	rders,	
							tment	
						11001201113 1160	шеш	
						Administration F	Record	
	(ii) A record of the r	resident's assessments;				(TAR) has treat	ments	• •
•	(iii) The comprehen	sive plan of care and services				documented as or	dered.	
	provided;						tment	1
						administration		
:		ny preadmission screening					for	
and resident review						resident #4 has	been	
	deferminations con	ducted by the State;				documented. Re	sident	
	(v) Physician's, nurs	se's, and other licensed				#5's July 2017	and	
	professional's progress notes; and					August 2017 Medi		
	( · \	Clarence of all the second				Administration F		
		ology and other diagnostic required under §483.50.						. ]
		√T is not met as evidenced				(MAR) is curren	-	
	by:	ty to not mot so evidenced				the Resident's (	linical	
		rview, facility document review				record. Residen	t #9's	
		eview, it was determined that		_		June 2017 MAR is		}
		d to ensure a complete and						
		cord for five of 34 residents in					clinical	
	#32.	Residents #4, #5, #9, #13 and					sident	-
	.,		-			number 13's June	2017,	
		ailed to document the ation for Resident #4.				July 2017 and A	∖ugust	
	#5's July 2017 and A	failed to maintain Resident August 2017 MAR's stration record) on the clinical						

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		E & MEDICAID SERVICES					FORM	APPROVED
	OF OEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MUI	TIPLE COI	VSTD	LICTION	L	). 0938-0391
ANO PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:						TE SURVEY MPLETEO
						<del> </del>		С
NAME OF		495362	B. WING				09	/29/2017
NAME OF	PROVIDER OR SUPPLIER		}			DRESS, CITY, STATE, ZIP CODE		
ASHLAN	ID NURSING AND RE	HABILITATION				SON STREET		
(X4) IO	SUMMARY STA	ATEMENT OF OEFICIENCIES		ASHL		, VA 23005		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		(E/	PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOUL( SS-REFERENCED TO THE APPROP OEFICIENCY)	DRE	IX5  COMPLETION OATE
F 514	#9's June 2017 MA  4. The facility staff #13's June 2017, June 2017, June 2017, June 2017 MAR's on the clinic 5. The facility staff f June 2017 MAR (morecord) in the reside The findings include 1. The facility staff f treatment administrative Resident #4 was ad 7/20/15 with a reading diagnoses that inclus chizophrenia (a growth drawal from soof thought, language response (1)), parapattempt, traumatic by pres sure and drug covers old.  The most recent ME	failed to maintain Resident R's on the clinical record.  failed to maintain Resident uly 2017, and August 2017 al record.  failed to file Resident #32's redication administration ent's clinical record.  failed to document the ation for Resident #4.  Imitted to the facility on mission on 10/30/15 with reded, but were not limited to: Dup of mental disorders pass distortions of reality, stal contacts and disturbances en perception and emotional plegia, edema, suicide prain injury, high blood overdose. Resident #4 was 47 occupied.	F 5	·	2.	2017 is currently in the Resident's clinical record. Resident #32's June 2017 MAR is currently in the residents clinical record. Medical Records has reviewed current residents clinical records for MAR's being filed in the clinical record for the past 3 months. The Administrator and or designee re-educated Medical Records staff including newly hired Medical Record Coordinator on filing MARS in the clinical record to ensure compliance is attained and maintained regarding filing three		CALE
	assessment, a quar assessment referen coded the resident a make daily decisions requiring extensive a	terly assessment, with an ce date (ARD) of 8/28/17, as being cognitively intact to s. The resident was coded as assistance for most of his ng. In Section M - Skin				months of MARS on the clinical records.		

Conditions, the resident was coded as having one

#### PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOING COMPLETEO 495362 B WING 09/29/2017 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL (X51 PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULO BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) 4. The Administrator and F 514 Continued From page 232 F 514 or designee to conduct stage !II pressure ulcer and one Stage !V quality monitoring of pressure ulcer. The dimensions of the unhealed Stage III or Stage IV pressure ulcer documented. maintaining the filing of 5.5 cm (centimeters) in length, 8.6 cm in width, MARS in the clinical and 5.4 cm in depth. It was coded as being "eschar - black, brown or tan tissue that adheres record for the most firmly to the wound bed or ulcer edges, may be current three months. softer or harder than surrounding skin. Quality monitoring of The MDS assessment, a quarterly assessment, MAR filing to be with an ARD of 7/5/17, did not code the resident-

Review of the June 2017 TAR (treatment administration record) documented, "Clean with normal saline apply bacitracin and cover." There was no start date on the order. The first documented date was on 6/19/17. There were blanks on 6/23/17, 6/26/17, 6/27/17 and 6/30/17, where the staff were to initial in the box that the treatment had been administered.

in Section M as having any pressure ulcers.

An interview was conducted with LPN (licensed practical nurse) #15 on 9/29/17 at 8:23 a.m. LPN #15 was asked to review the June TAR for Resident #4. When asked what the blank boxes on the treatment orders indicate, LPN #15 stated, "If nothing is in the box, then it's either someone didn't sign it or it wasn't done."

An interview was conducted with LPN #6, the unit manager, on 9/29/17 at 8:24 a.m. LPN #6 was asked to review the June TAR for Resident #4. When asked what the blank boxes on the treatment orders indicate, LPN #6 stated, "Blanks are if not documented, it's not done."

An interview was conducted with ASM (administrative staff member) #2, the director of

conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. results of the quality monitoring to reviewed a the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.

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		* & MEDICAID SERVICES	<del></del>			OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495362	B. WING	è			С
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	0	9/29/2017
A CTULAN	ID NUDCING AND DE	HABIE ITATION					
ASHLAN	ID NURSING AND RE	HABILITATION		l	THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DUIDBE	(X5) COMPLETION DATE
F 514	Continued From pa	nge 233	_	514			
		rsing, on 9/29/17 at 8:35 a.m.	r	314	·		
		blank boxes on the TAR					
		tated, "It's either the treatment					
		charted or the treatment was					
	not done."	•					•
	The facility policy. "	Clinical/Medical Records"					
	documented in part	, "Clinical Records are	_		•		-
. [ . [ . ]		rdance with professional			-		
		to provide complete and					
		n on each resident for The purpose of the clinical			•		
		ent the course of the resident's					
	plan of care and to	provide a medium of					
		ong health care professionals					· · · · · · · · · · · · · · · · · · ·
	involved in this care	· ·					<del>.</del>
	The following quote	tion is found in Potter and					
		als of Nursing 6th edition					** *
	(2005, p. 477): "Do	cumentation is anything					· · · · · · · · · · · · · · · · · · ·
		at is relied on as record or					
		persons. Documentation cal record is a vital aspect of			-		
		ursing documentation must be	٠.				-
	accurate, comprehe	ensive, and flexible enough to			•		-
		, maintain continuity of care,		-			
		es, and reflect current					
		g practice. Information in the ess a detailed account of the			-		.=
		re delivered to the clients."					
	Potter and Perry (20	005) also includes the					
		n: "As members of the health					
		leed to communicate ients accurately and in a					
	timely, effective mai						
	·		•				. ,
		aware of the above concern .m. No further information					-

was provided by completion of the survey.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		495362	B. WING		05	C 9/29/2017
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	DE	72072013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(= -:	SHOULD BE	(X5) COMPLETION DATE
F 514	F 514 Continued From page 234			514		
		ary of Medical Terms for the er, 5th edition; Rothenberg and 2.				
	#5's July 2017 and	failed to maintain Resident August 2017 MAR's stration record) on the clinical		·		
	4/28/14 with the dia heart disease, dysp blood pressure, urin chronic kidney disea	Imitted to the facility on gnoses of but not limited to: hasia, epilepsy, diabetes, high hary retention, alcohol abuse, ase, and coronary artery	÷			

4/28/14 with the diagnoses of but not limited to: heart disease, dysphasia, epilepsy, diabetes, high blood pressure, urinary retention, alcohol abuse, chronic kidney disease, and coronary artery disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/27/17. Resident #5 was coded as being cognitively intact in ability to make daily life decisions. The resident was coded requiring total care for bathing; extensive care for hygiene, transfers, and dressing; supervision for eating; as having a catheter for bladder and as incontinent of bowel.

A review of the clinical record was conducted to review the MAR's (Medication Administration Record) for June 2017, July 2017 and August 2017. The MARs were not filed on the chart. On 9/28/17 at 5:20 p.m., at the end of day meeting with the administrator/executive director ASM (administrative staff member) #1, Resident #15's MAR's were requested for review. On 9/29/17 at approximately 8:30 a.m., ASM #1 stated the July 2017 MAR's and August 2017 MAR's could not be located. She stated that a nurse that was fired was suspected of throwing documents away after she was fired.

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	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CO	(X3)	DATE SURVEY	
		495362	B. WING				C 09/29/2017
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		906 TI	ET ADDRESS, CITY, STATE, ZIP CO HOMPSON STREET _AND, VA 23005	DDE	09/29/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD RE	(X5) COMPLETION DATE
F 51.4	the survey.  3. The facility staff	on was provided by the end of	F 5	514			
	Resident #9 was ac 4/19/17 with the dia altered mental statu disorder, borderline depression, anxiety stroke, and catarac (Minimum Data Set with an ARD (Asses 7/27/17. Resident # moderately impaired decisions, scoring a BIMS (Brief Interviee The resident was coassistance for bathicating and ambulations).	R's on the clinical record.  Imitted to the facility on gnoses of but not limited to: is, dementia, delusional personality disorder, chronic kidney disease, ts. The most recent MDS ) was a quarterly assessment esment Reference Date) of 49 was coded as being d in ability to make daily life a 9 out of a possible 15-on the w for Mental Status) exam. oded as requiring extensive no; supervision for hygiene, ion; as independent for nent of bowel and bladder.					
-	review Resident #9' Administration Reco and August 2017. The chart. On 9/28/17 at meeting with the Ad ASM #1, Resident #1 review. On 9/29/17 the ASM #1 stated the control be located. She fired was suspected after she was fired.	cal record was conducted to s MAR's (Medication ord) for June 2017, July 2017 They were not filed on the at 5:20 p.m., at the end of day ministrator/Executive Director, 19's MAR's were requested for at approximately 8:30 a.m., he June 2017 MAR's could e stated that a nurse (hat was lof throwing documents away	 - 	- -			
	No further information	on was provided by the end of					

the survey.

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,	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CDRRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVE COMPLETED	
			495362	B. WING			C 09/29/2017
	_	ROVIDER OR SUPPLIER  NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP COI 906 THOMPSON STREET ASHLAND, VA 23005	DE	
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		HOULD BE	IX5I COMPLETION DATE
	F 514	Continued From pa	ge 236	F 5	i14		
		_	failed to maintain Resident uly 2017, and August 2017 al record.		,		·
		6/18/12 with the dia	admitted to the facility on agnoses of but not limited to:				. · . · ·

Resident #13 was admitted to the facility on 6/18/12 with the diagnoses of but not limited to: high blood pressure, chronic obstructive pulmonary disease, dysphagia, diabetes, adult failure to thrive, dementia, schizophrenia, schizo-affective disorder, depression, and bipolar disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/3/17. Resident #13 was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for hygiene and dressing; supervision for transfers, ambulation, and eating; and as usually continent of bowel and bladder.

A review of the clinical record was conducted to review Resident #13's MAR's (Medication Administration Record) for June 2017, July 2017 and August 2017. They were not filed on the chart. On 9/28/17 at 5:20 p.m., at the end of day meeting with the Administrator/Executive Director, ASM #1, the MAR's were requested for review. On 9/29/17 at approximately 8:30 a.m., the ASM #1, stated Resident #13's June 2017, July 2017 MAR's and August 2017 MAR's could not be located. She stated that a nurse that was fired was suspected of throwing documents away after she was fired.

No further information was provided by the end of the survey.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			_	FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2] MUI	LE CONSTRUCTION	MB NO. 0938-0391	
70.00	or detailer for	IDENTIFICATION NUMBER:	A. BUILD	DING		(X3] DATE SURVEY COMPLETED
		495362	B. WING			С
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	09/29/2017
ASHLAN	ID NURSING AND RE	HARII ITATION			06 THOMPSON STREET	
				ı	ASHLAND, VA 23005	
(X4) ID PREFIX	SUMMARY STA (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION	N (X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COURTED
F 514	Continued From pa	ge 237	F	514		
,	5. The facility staff f June 2017 MAR (m record) in the reside	ailed to file Resident #32's edication administration ent's clinical record.				
	5/26/17. Resident # were not limited to: the spinal cord and #32's most recent M quarterly assessme	dmitted to the facility on 32's diagnoses included but anxiety disorder, disease of osteomyelitis (1). Resident 1DS (minimum data set), a nt with an ARD (assessment 12/17, coded the resident as act.	- - - -			
	Review of Resident reveal the resident's	#32's clinical record failed to June 2017 MAR.				
	staff member) #2 (the services) stated she MAR. ASM #2 was filing MARs. ASM #3 new month, the MAR sent to the MDS emp	a.m., ASM (administrative e director of nursing/clinical could not locate the above asked the facility process for 2 stated on the first day of the 3 from the previous month is ployees for review then the ployee is supposed to file the				
	On 9/29/17 at 11:29 a director/administrator aware of the above c	a.m. ASM:#1 (the executive r) and ASM #2 were made oncern.				
_	No further information	was presented prior to exit.	-			
i	nformation was obtain	bone infection. This ned from the website: en/teens/osteomyelitis.html				-